

## Legislative Commission on Primary Care Workforce Issues

July 27, 2017 2:00-4:00pm at the NH Medical Society Conference Room, Concord

### Call in information:

866-939-8416

Participant Code: 1075916

### Agenda

- |             |  |
|-------------|--|
| 2:00 - 2:10 | <b>Introductions &amp; Minutes</b>   |
| 2:10 - 2:55 | <b>Roxie Severance, Health Sector Intermediary, NH Health Care Association, NH Sector Partnerships Initiative and Phil Przybyszewski, Workforce Solutions Project Director, Community College System of NH, NH Sector Partnerships Initiative</b> - The Sector Partnership Initiative (SPI) is a new industry-driven statewide initiative to help businesses in targeted industries address their workforce needs, while also helping workers prepare for and advance in careers in these critical sectors. The initiative is initially focusing on four industries: manufacturing, hospitality, healthcare, and information technology. How can we work together? |
| 2:55 – 3:50 | <b>Alexander Blount, Director of the Major Area of Study in Behavioral Health Integration and Population Health, Antioch University New England – New Hampshire Primary Care Behavioral Health Workforce Development Plan</b>  |
| 3:50 – 4:00 | <b>Updates and next meeting</b>  |

**Next meeting: Thursday September 28 2:00-4:00pm (No Meeting in August)**

**State of New Hampshire**  
**COMMISSION ON PRIMARY CARE WORKFORCE ISSUES**

DATE: July 27, 2017

TIME: 2:00 – 4:00pm

LOCATION: New Hampshire Medical Society

**Meeting Minutes**

**TO:** Members of the Commission and Guests

**FROM:** Danielle Weiss

**MEETING DATE:** July 27, 2017

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**Members of the Commission:**

Laurie Harding – Chair

Stephanie Pagliuca, Director, Bi-State Primary Care Association

Mary Bidgood-Wilson, ARNP, NH Nurse Practitioner Association

Kristina Fjeld-Sparks, Director, NH AHEC

Jeanne Ryer, NH Citizens Health Initiative

Mike Ferrara, Dean, UNH College of Health and Human Services

Scott Shipman, MD, Director, Primary Care Affairs and Workforce Analysis, AAMC

Bill Gunn, NH Mental Health Coalition

**Guests:**

Danielle Weiss, Program Manager, Rural Health and Primary Care Section

Paula Smith, SNH AHEC

Nancy Frank, Executive Director, NNH AHEC

Rob Kiefner, MD, NH Academy of Family Physicians

Peter Mason, Geisel School of Medicine

Guy Defeo, MD, Associate Dean for Clinical Education, UNE

Anne Marie Mercuri, QI Nurse, Maternal and Child Health Section

Claire Reed, MD, Chief Medical Officer, Mid-State Health Center

Barbara Mahar, New London Hospital

Nick Toumpas, Region 8 IDN

Marcy Doyle, NH Citizens Health Initiative

Kristine Stoddard, Bi-State Primary Care Association

Sarah Courier, Dir. Workforce Development Dartmouth-Hitchcock

Phil Przybyszewski, Community College System of NH, NH Sector Partnerships Initiative

DC Bates, NH House Committee on Health Care Research

Joan McMure, Exec. Dir. NH Nurses Association

Michael Power, Workforce Community Development, NH Dept. of Resources & Economic Development

Jeanne Mitchell, NPRN, UNH

**Meeting Discussion:**

2:00 - 2:10      **Introductions & Minutes**

2:10 - 2:55      **Roxie Severance, Health Sector Intermediary, NH Health Care Association, NH Sector Partnerships Initiative and Phil Przybyszewski, Workforce Solutions Project Director, Community College System of NH, NH Sector Partnerships Initiative** - The Sector Partnership Initiative (SPI) is a new industry-driven statewide initiative to help businesses in targeted industries address their workforce needs, while also helping workers prepare for and advance in careers in these

critical sectors. The initiative is initially focusing on four industries: manufacturing, hospitality, healthcare, and information technology. How can we work together?

Refer to the presentation “NH Sector Partnerships Initiative.”

- The Sector Partnerships Initiative is looking for funding options to encourage work here
- There may be a variety of funding sources available
  - o Department of Labor gets federal funding for unemployed adults and dislocated workers to get job training
    - NH Works (consortium of NH agencies) has individual training accounts
  - o Job training fund – employer based
    - 1-1 match for training
    - Employer who pays quarterly tax
    - Distribute \$1M/year to upgrade skills of staff
    - Served 700 companies
  - o Apprenticeship funds
  - o Work-based learning group
  - o On-the-job training
  - o Apprenticeship USA program
    - Up to \$2k for displaced worker
- There’s one year left for funding but the idea is that the Sector would maintain work once it matured

2:55 – 3:50

**Alexander Blount, Director of the Major Area of Study in Behavioral Health Integration and Population Health, Antioch University New England** – New Hampshire Primary Care Behavioral Health Workforce Development Plan

Refer to the slides “Behavioral Health/Primary Care Integration.”

3:50 – 4:00

**Updates and next meeting**

**Next meeting: Thursday September 28 2:00-4:00pm (No Meeting in August)**



**NEW HAMPSHIRE SECTOR PARTNERSHIPS INITIATIVE (SPI)**

**Legislative Commission of Primary Care Workforce Issues  
July 27, 2017**

- What is a Sector Partnership?
- How does SPI work?
- Where are we in the process?
- How can you help?
- Q & A



# What Is A Sector Partnership Initiative?

- Established by the (Workforce Innovation & Opportunity Act (WIOA) in 2014
- Mandates that all states adopt a Sector Strategies approach to workforce development.
- Start-up is funded by a DOL, NEG grant in the amount of \$2.4M
- Funding ends on June 30, 2018

- Employers are challenged to meet their hiring needs, thus limiting their competitiveness and their ability grow.
- Employers partner with their peers and key support stakeholders to identify common issues.
- Industry-led partnerships address their ongoing workforce challenges and develop viable solutions.

The SPI model works because it is designed to be highly responsive to industry demand compared to traditional models because:

- Problem-oriented, not program oriented
- Addresses needs interdependently, not independently
- Works with companies collectively, not as individual firms

Initial data analysis performed in early 2016 brought focus to the following four industry sectors:

- Manufacturing
- Technology
- Health Care
- Hospitality

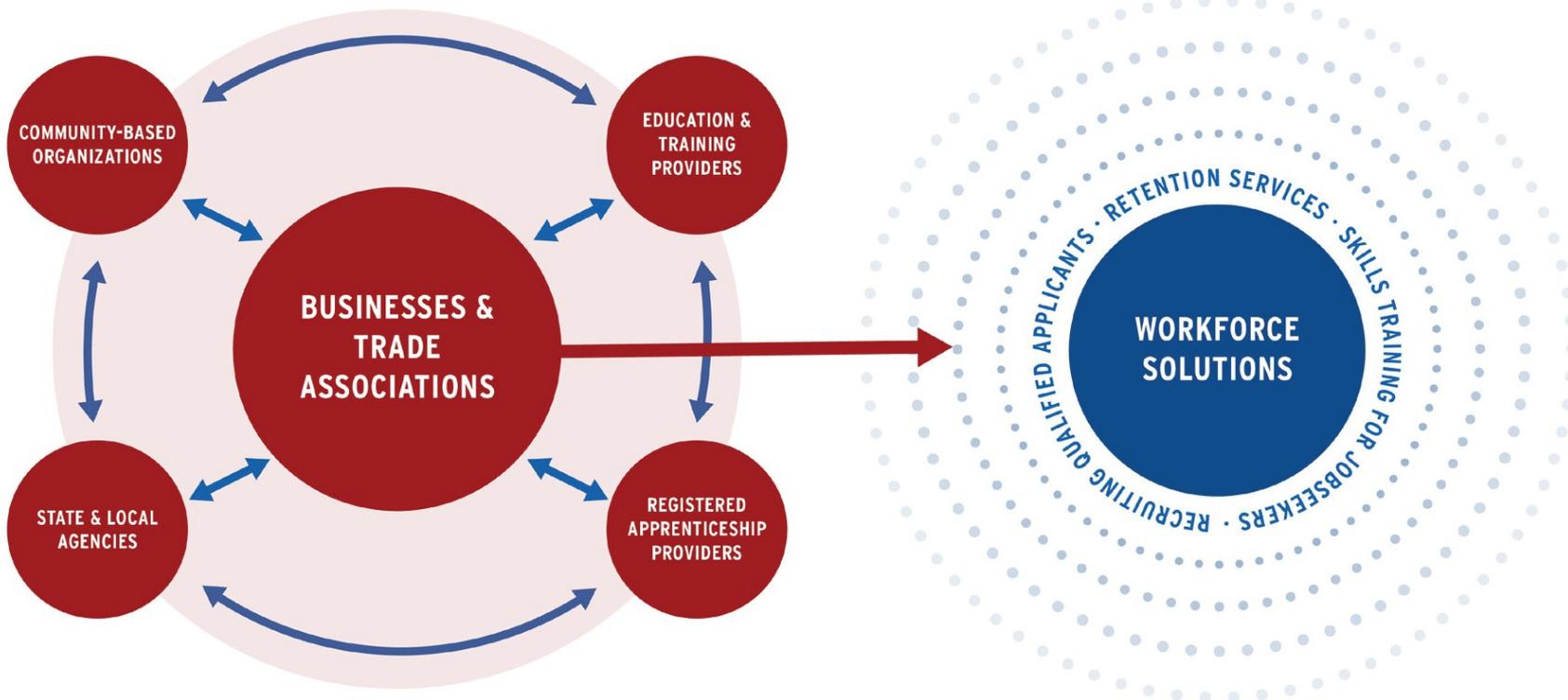
Currently exploring the addition of a fifth:

- Infrastructure



## How does SPI work?

- **Labor Market Analysis**
  - Identify target sectors, job skills, education & other requirements
- **Asset Mapping**
  - Identify existing assets/resources to support the sector.
- **Workforce Planning**
  - Identify sector champions & intermediaries to manage sustainable leadership teams & working committees.
- **Sector Launch**
  - In-person event to share data, findings, etc. and develop high-level plans for partnership next steps.
- **Post-Launch Activity**
  - Working committees drive detailed initiatives to meet workforce needs.
  - Deploy \$1M of grant funded supports (\$330K tuition payments, \$680K OJT reimbursements, \$30K other support services).





## Where Are We In The Process?

- Industry Sector Champions
- Industry Sector Intermediaries
- DBEA - Chris Way
- CCSNH - Charlotte Williams
- OWO - Jackie Heuser & Michael Power
- DOE/CTE - Eric Feldborg
- DOL, Office of Apprenticeship - Lauren Smith
- SNHS/WIOA – Matt Russell
- Office of the Governor - TBD
- Economic & Labor Market Info. Bureau – Trina Evans
- Jobs For the Future (sector strategies consultant)

- Recognized leaders in the industry
- Committed to the vision
- Willing to use their power & prestige to:
  - Engage their industry peers
  - Co-author correspondence to potential members
  - Convene meetings to discuss issues/solutions
  - Maintain momentum of workgroups
- Work with the Industry Intermediary to perform the above tasks and drive the initiative

- Recognized entity in the industry
- Committed to the vision
- Supports Industry Sector Champions by:
  - Serving dual customers (employers & workers)
  - Organizing multiple partners & funding streams
  - Convening meetings to discuss issues/solutions
  - Providing outreach to existing and new initiative members to sustain momentum
  - Maintaining relationships and sector materials
- Be the primary support for the Industry Sector Champions to perform the above tasks and drive the initiative

Process Step	Status	Estimated Timeline
Labor Market Data	Completed	March
Asset Mapping	In-Process	January
Workforce Planning	In-Process	January
Sector Launch	In-Planning	March 8, 2017
Post-Launch Activity	TBD	March & Beyond

Sector Chair: Sarah Currier, Dartmouth Hitchcock

Sector Vice-Chair: Lynda Goldthwaite, Aurora Senior Living

Sector Intermediary: Roxie Severance, NH Health Care Assn.

## Key Initiatives To-Date

- Finalized Intermediary assignment (SWIB funded)
- Supporting efforts at Dartmouth-Hitchcock and Exeter Health Resources
- Promoting apprenticeships leveraging CCSNH grant
- Monitoring NH-JAG program for LNA credentialing & career planning at Havenwood-Heritage Heights
- Monitoring early stages of an LNA credentialing & career planning project at MCC – hybrid 40 to 50 hours online learning and 60 hours of in-field clinical work
- Starting to engage with Mt. Washington Valley Regional Collaborative
- Convening trade associations to meet with Board of Nursing



# How Can You Help?

- Learn more about SPI at <http://www.nhworks.org/Sector-Partnership-Initiative/Overview/>
- Support the effort
  - Identify potential training participants
  - Talk it up with your peers
  - Consider a role on a sector committee
  - Submit ideas or examples of industry challenges and possible solutions



The Sector Partnership Initiative received a Best of Business Award from NH Business Review for **“Best Way to Address The Skills Gap”!**

# Contact

Phil Przybyszewski

Workforce Solutions Project Director,  
NH Sector Partnerships Initiative

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nhworks.org



Center for  
Behavioral Health  
Innovation

**ASSESSING AND DEVELOPING THE WORKFORCE  
FOR THE INTEGRATION OF BEHAVIORAL HEALTH  
AND PRIMARY CARE IN NEW HAMPSHIRE**

ALEXANDER BLOUNT, ED.D.

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# Purpose for today:

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1. Initiate or increase contact and communication among the Primary Care Behavioral Health (PCBH) workforce stakeholders.
2. Develop a shared understanding of NH's PCBH workforce needs in light of state data and the national literature.
3. Sketch a shared vision of the NH PCBH workforce development network of the future.

# Scope PCBH Workforce Assessment Study

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Focused only on primary care behavioral health workforce in New Hampshire

Assessing how behavioral health care is delivered to the most “stressed” populations

Studied the “safety net” clinics (FQHCs and look alike plus RHCs)

Looked at how well the training infrastructure of the state is poised to produce the workforce needed to supply these sites and by extension, the state.

# Our Workforce Advisory Team

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**Sharon Beaty, MBA, FACMPE**

Executive Director, Mid-State Health Center

**Peter Fifield, EdD, MLADC**

Director of Behavioral Health, Families First

**Carol Furlong, MBA, MSEd**

VP, Operations, Harbor Homes

**William Gunn, PhD**

Asst. Professor of Community and Family Medicine, Dartmouth Medical School

**Will Torrey, MD**

Professor of Psychiatry, Dartmouth Medical School

# Primary Care Behavioral Health

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Is PCBH an extension of the overall behavioral health service system?

Is it a completion of primary care services?

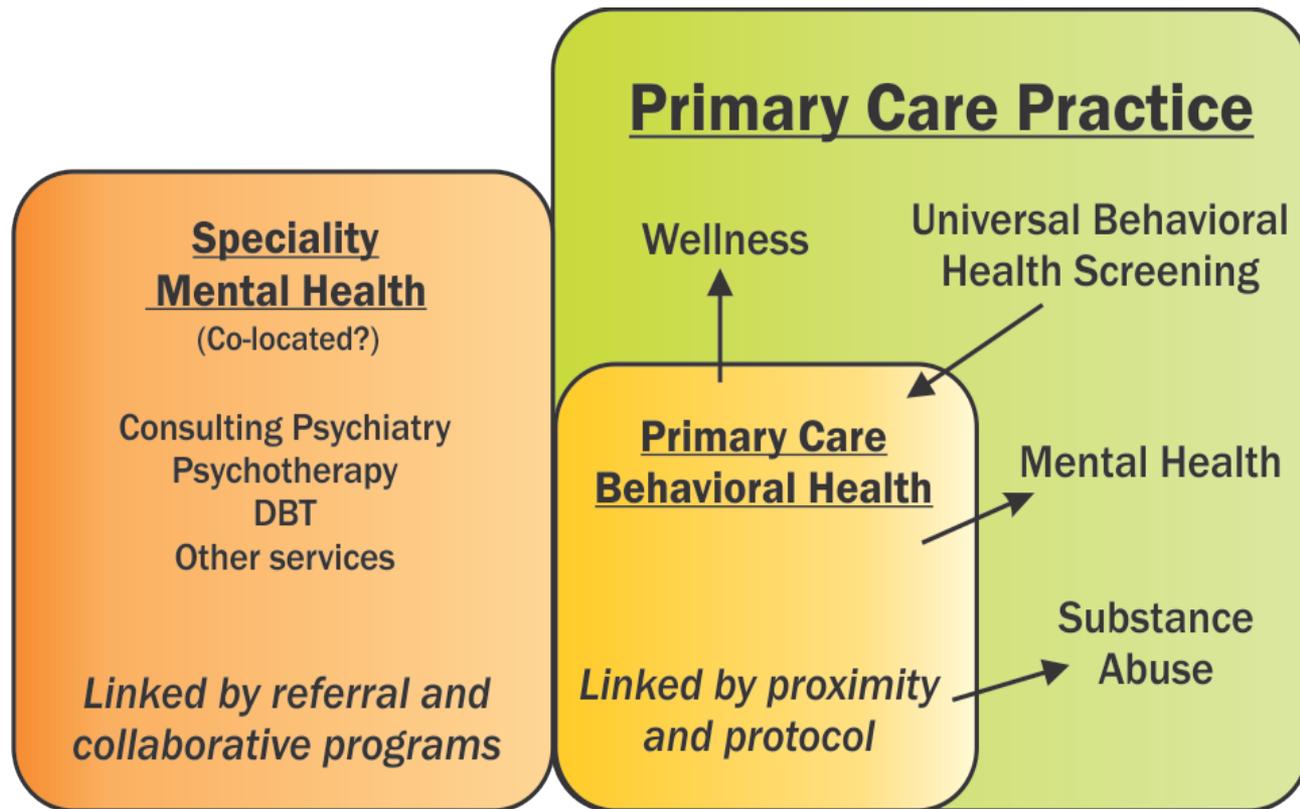
It is both, but to realize its potential for improving care and reducing cost, it works better if PCBH is implemented as a completion of primary care.

Take time to have a look at the exemplars:

[https://integrationacademy.ahrq.gov/sites/default/files/AHRQ\\_AcademyGuidebook.pdf](https://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcademyGuidebook.pdf)

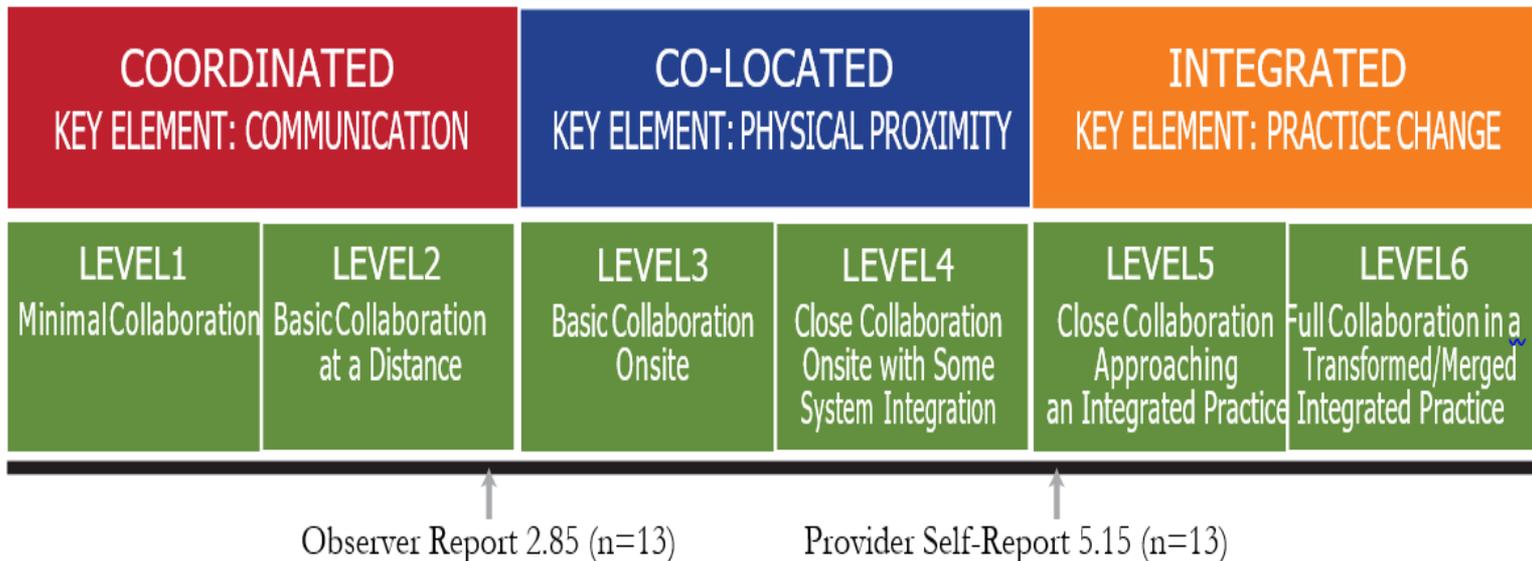
Integrated Primary Care needs a healthy specialty mental health and substance abuse system and vice versa.

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The practices perceived themselves as more integrated than we suspect they are.

## Observer versus Site Perceptions of Level of Integration



# We defined behavioral health broadly.

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1. Prescribing and consulting about psychotropic medications
2. Consulting with PCPs and other team members about patient BH needs and treatment.
3. Providing behavioral interventions or therapies for mental health and substance abuse needs and health behavior change
4. Creating and maintaining patient engagement in care
5. Addressing health literacy, adherence, and healthy living
6. Keeping information about the patient's health needs and health behavior flowing between the patient and the health team
7. Addressing social and economic barriers patients face in caring for their health (“social determinants of health”)

# Role of “Care Enhancers”

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Lots of roles being added:

Care Manager

Care Coordinator

Navigator

Translators

Health Coach

Patient Advocate

Community Health Worker

Patient Educators

(and on and on)

Some are new types of training and some are new roles for existing disciplines (RNs, LPNs, MAs, MSWs)

Whatever their training, these roles require behavioral skills.

We conceptualized the workforce by categories of function rather than discipline.

## Care Enhancer (CE)

- BSW, Med Asst, Care Manager/Coord, Health Coach, CHW, Pt. Educator, Navigator, Reg. Nurse, BS Nurse

## Consulting Psychiatric Clinician (CPC)

- Psychiatrist (MD, DO), Psych Nurse Practitioner, Psych Advanced Practice Nurse, Psych Physician's Assistant

## Behavioral Health Clinician (BHC)

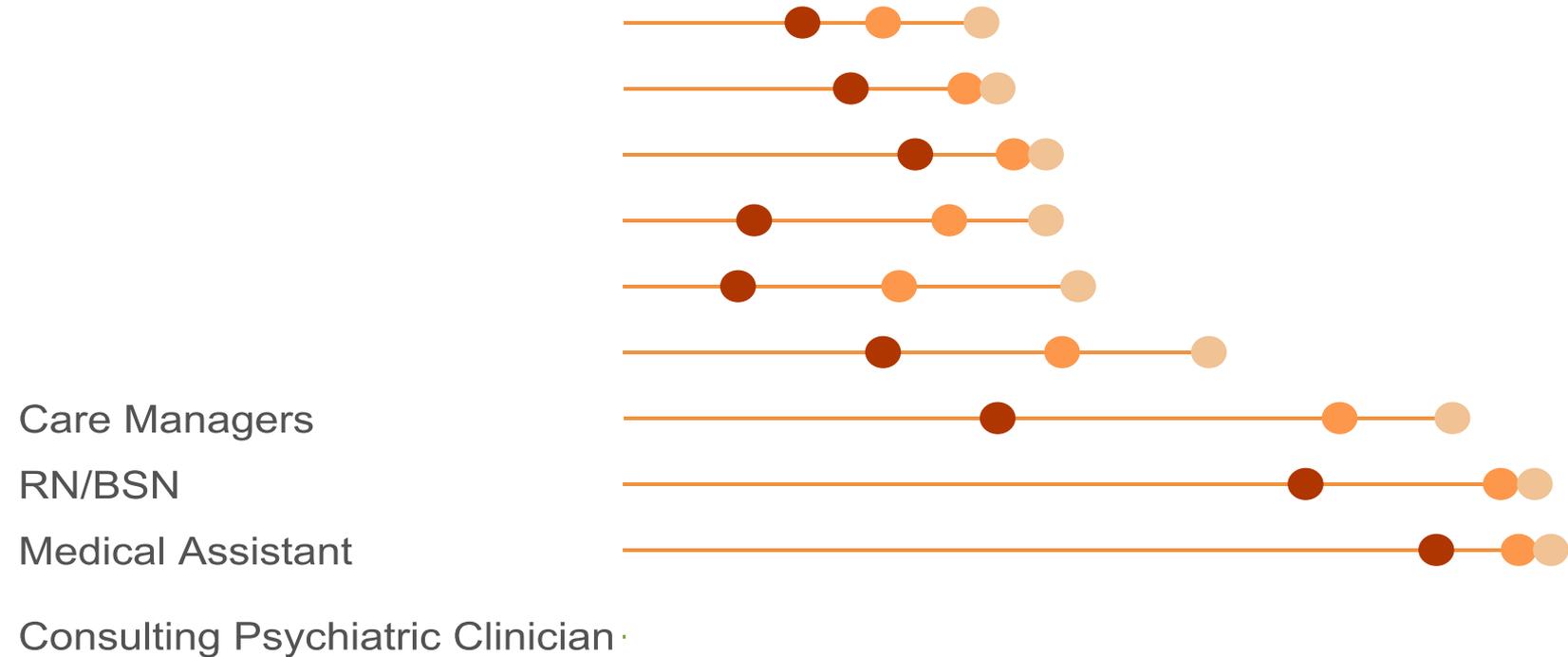
- Psychologist (PsyD, Phd), Marriage & Family Therapist, Substance Abuse Counselor, Mental Health Counselor, MSW

# BHCs, PCCs, & some forms of CE's will be in great demand.

## Substance Abuse Counselors, Care Managers, BHCs Needed

Number of Professionals: **Now**, Wanted Now, Wanted in 5 years

Care Enhancers, Consulting Psychiatric Clinicians, Behavioral Health Clinicians



# The Fourth Core Role in BHI

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**Primary Care Clinicians** – (MD/DOs, APRNs, PAs working in Family Medicine, General Internal Medicine, Pediatrics, and sometimes OB/GYN)

We did not study this workforce because a number of federal and state agencies already do so.

Yet PCCs play a core role in the success of BHI.

They are already treating depression, anxiety, SA, ADHD, chronic pain, Medically Unexplained Symptoms, and non-adherence, usually presenting in multiples along with chronic illnesses.

Members of other roles who are skilled in behavioral health, at working on a team, and at supporting team members make a crucial difference for PCCs

When co-location and integration are done well, PCCs' job satisfaction goes up and (anecdotally) so does provider retention. This is an important workforce intervention.

We believe “substance abuse counselors” should be identified and trained as “behavioral health clinicians.”

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Primary care patients usually present substance use problems as part of larger arrays of concerns. Treating the “whole person” doesn’t mean treatment for only a particular BH problem any more than treating only physical problems.

The BHC who engages them in working on their behavioral health issues has to be defined as a generalist who can competently address unhealthy habits or depression or substance use, depending on where the patient is ready to work.

The 42 CFR permits generalist behavioral health and medical professionals in general medical settings to communicate about substance abuse diagnoses and treatment without additional permission from the patient.

# Academic Programs

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Overall response rate of 40%

Master's programs training therapists were largely unaware of their graduates as BHCs. Response rate much better – 86%

In general, the academic programs are well behind the primary care sites in knowledge of behavioral health integration.

The majority of respondents, whether they know about IBH or not expressed interest in learning more and in being involved if there was a role they could discern.

# Training needs:

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The literature and general experience says that BH clinicians need targeted training in addition to their curricula in graduate school to be able to succeed in primary care. Many programs have failed when this training was not required. (Hall, Cohen, Davis, et al., 2105).

It may make more sense to develop or contract for a post-degree training program rather than trying to insert the necessary training into the packed curricula in Master's graduate programs.

Successful and extensively evaluated training programs are currently available online.

Additional training for Care Enhancers, Primary Care Clinicians and Consulting Psychiatric Clinicians are also available.

# As BHI matures, workforce needs evolve

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More uses for BHCs, and new ways of using CEs and PCCs in the BH endeavor.

The first job is retraining the members of the current workforce who want to be a part of BHI.

Then we want to identify academic programs that want to make this training a priority.

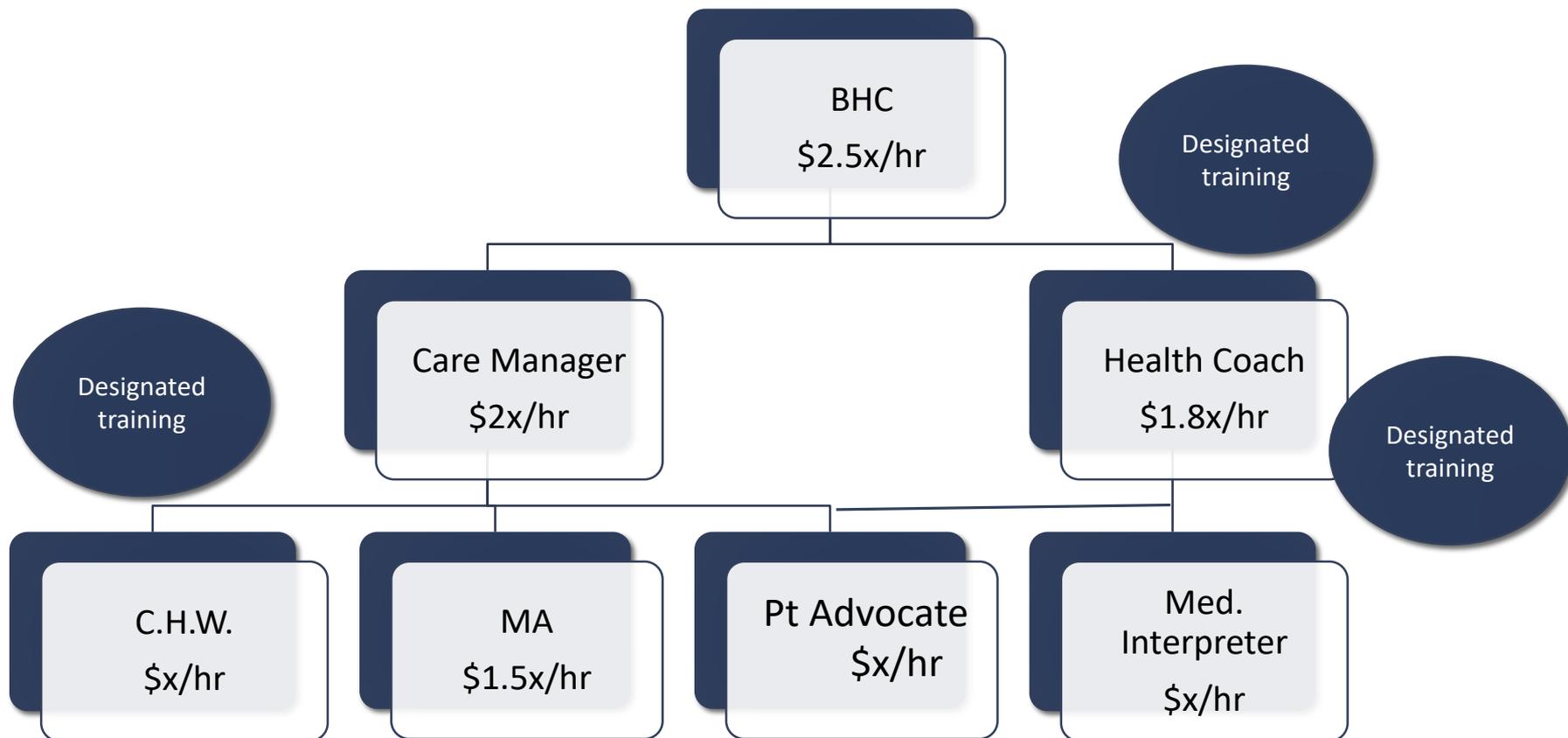
As an example, Antioch has established a Major Area of Study in Behavioral Integration and Population Health.

The same could happen for Care Enhancer roles, i.e., post graduation modular training in new competencies with a few programs deciding to make this a priority for the future.

# Doorways and Pathways

## A Rationalized System Draws Workforce

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# New Hampshire Primary Care Behavioral Health Workforce Development Plan

By Alexander Blount

With the guidance and support of: Laura J Bilodeau, Annamarie Cioffari, James Fauth, Nancy Frank, Suzanne Gaetiens-Oleson, Hwasun Garin, Joni Haley, Fred Kelsey, Will Lusenhop, JoAnne Malloy, Patrick Miller, Stephanie Pagliuca



# Strategic Planning Committee Members

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**Laura J. Bilodeau**, Department Chair of Liberal Arts, Manchester Community College

**Annamarie Cioffari**, Director, Southern New Hampshire Graduate Program in Clinical Mental Health Counseling

**James Fauth**, Director, Center for Behavioral Health Innovation, Antioch University New England

**Nancy Frank**, Executive Director, North County Health Consortium/ Northern New Hampshire Area Health Education Center

**Suzanne Gaetiens-Oleson**, Regional Mental Health Administrator, Northern Human Services

**Hwasun Garin**, Project Director, Institute for Health Policy and Practice, University of New Hampshire

**Joni Haley**, Manager of Behavioral Health Services, Concord Hospital Family Health Center

**Fred Kelsey**, Medical Director Emeritus, Mid-State Health Center

**Will Lusenhop**, Clinical Assistant Professor, Department of Social Work, University of New Hampshire

**JoAnne Malloy**, Clinical Assistant Professor, Institute on Disability, University of New Hampshire

**Patrick Miller**, Principal, Pero Consulting Group LLC.

**Stephanie Pagliuca**, Recruitment Director, Bi-State Primary Care Association

# Plan for Current PCBH Workforce

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1. Identify available & effective PCBH training programs
2. Seek funding for training from IDN's
3. Negotiate discounted NH rates
4. Offer live Q & A and coaching to current BHCs

# Plan for Developing the Future PCBH Workforce.

1. Elicit input from academic programs for PCBH modules that orient students to primary care as a possible venue for future employment.
2. Develop these modules for undergrad, masters and doctoral programs.
3. Create and maintain a PCBH web portal for current and future workforce members.
4. Create a list of Care Enhancer roles, training pathways and salaries.
5. Identify training programs for primary care workers that can lead to PCBH licensure (masters clinician) without leaving employment.
6. Create a consensus list of Care Enhancer behavioral competencies and career ladder.
7. Created manual and tool/kit to help primary care sites initiate training positions.
8. Develop training modules in PCBH for psychiatric APRNs, trainees and staff.

# Plan to Develop Integrated Leadership and Workflows

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1. Develop a PCMH/NCQA/PCBH “cross walk” of requirements
2. Identify PCBH approaches that create sustainability outside F-F-S
3. Create pediatric-specific workflows and practice webinars
4. Create/deliver PCBH training for C.H.I. primary care practice facilitators
5. Create a webinar on PCBH levels and opportunities for practice and health system leaders
6. Identify and disseminate a list of IDN and other statewide PCBH workforce efforts

# Carrying Out the Plan

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- We are funded for two years by the Endowment for Health
- I am the P.I. (“University speak” for project leader)
- We have student and professional staff support within the Center for Behavioral Health Innovation from the Department of Clinical Psychology at Antioch University New England.
- For almost every sub-project we have identified, one or more partners from around the state will join us. (See “Responsible Organization/Other Participants” column in Plan).
- The role of partner is not closed. Where we can work in partnership we would like to. Where someone else is undertaking specifically what we have committed to do, we are happy to defer and consult.



# New Hampshire Sector Partnerships Initiative

## Challenge

New Hampshire employers in many sectors are struggling to meet their hiring needs and find skilled workers. This limits your competitiveness, and the of the state's economy.

## The Solution

Join other businesses and key players to identify common workforce challenges. This partnership can provide training, services, and solutions that recruit, retain, and retrain workers.

## The Ask

Employers and other key partners contribute their time to work with their peers to create a lasting, business-led partnership that addresses your workforce challenges. You contribute directly to the solutions we all need.

## OVERVIEW

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NH Sector Partnerships Initiative (NH SPI) is a new, **industry-driven** statewide initiative to help businesses in targeted industries address their workforce needs, while also helping workers prepare for and advance in careers in these critical sectors. The initiative is initially focusing on four industries: **manufacturing, hospitality, health care, and information technology.**

Through this innovative public/private collaboration, groups of businesses within each target industry participate in sector partnerships, formal collaborations where they convene on a regular basis to identify shared hiring, training, and retention needs. Businesses then work with a range of critical partners to develop training programs and other workforce services to address businesses' shared workforce needs.

### These partners include:

- Community-based organizations
- Education and training providers like career and technical education centers and community colleges
- Registered apprenticeship providers

The workforce solutions developed through these partnerships will simultaneously help workers prepare for jobs and advance in these critical industries.

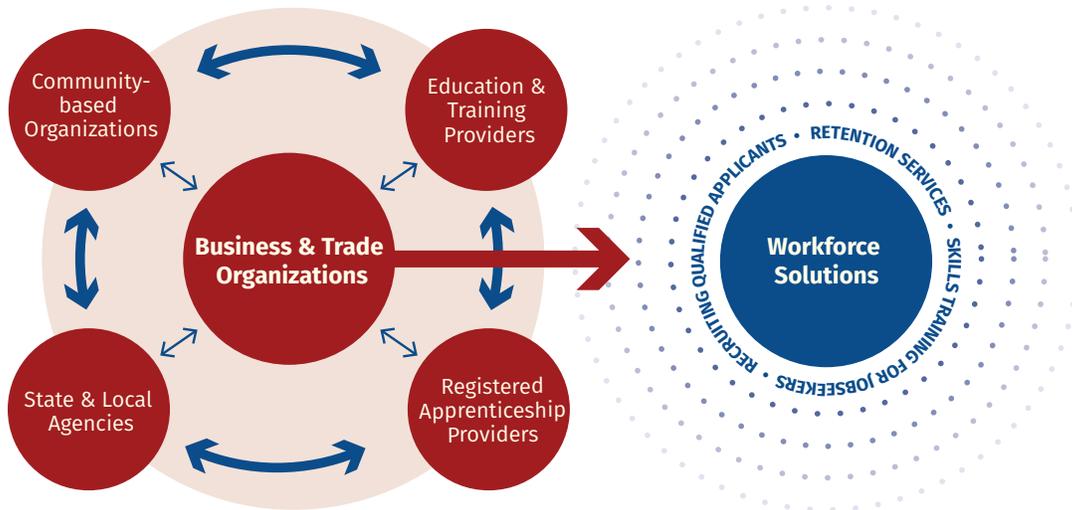
The statue conducted a comprehensive labor market analysis of the targeted sectors, as well as identified existing resources throughout the state that can be leveraged to support these partnerships. Sector partnerships in the targeted industries are launching, and employers are critical in helping develop new training programs or refining existing services based on business needs.

## KEY STAKEHOLDERS

NH SPI is **industry-driven** – businesses within the targeted industries lead each sector partnership, working with their peers and other key industry partners to identify and address their common workforce needs. The initiative is supported by NH Works, a consortium of state agencies and associations working together to leverage their staff and align their local networks to support the sector partnerships.

### How NH SPI Works

The Sector Partnerships Initiative is industry-driven



## SECTORS

NH SPI is initially focusing on four industries: **manufacturing, hospitality, health care,** and **information technology.** We will expand to new sectors as the demand develops.



**MANUFACTURING**



**HOSPITALITY**



**HEALTH CARE**



**INFORMATION  
TECHNOLOGY**

**For more information or to get involved, contact:  
Phil Przybyszewski, Workforce Solutions Project Director**



603.206.8185



[pprzybyszewski@ccsnh.edu](mailto:pprzybyszewski@ccsnh.edu)



[www.nhworks.org](http://www.nhworks.org)

# THE NEW HAMPSHIRE HEALTH CARE SECTOR PARTNERSHIP



Asset Map and Recommendations: March 2017



**nhworks**

A proud partner of the AmericanJobCenter network



**JOBS FOR THE FUTURE**

## ACKNOWLEDGEMENTS

NH Works and Jobs for the Future are grateful to the many people who have supported and guided the development of this report.

**New Hampshire Sector Partnerships Initiative** team members have provided excellent guidance for the development of sector partnerships in health care and other key sectors and been critical in shaping this report. Team members include Jackie Heuser and Michael Power of the Department of Resources and Economic Development (DRED); Phil Pryzbyszewski and Charlotte Williams of the Community College System of New Hampshire; Lauren Smith of the Office of Apprenticeship, U.S. Department of Labor; Katrina Evans of the Economic and Labor Market Information Bureau, New Hampshire Employment Security; Eric Feldborg and Jeffrey Beard of Career and Technical Education, New Hampshire Department of Education; Paula Philbrook of Southern New Hampshire Services, Inc.; Carmen Lorenz, formerly of DRED; and Brittany Weaver, formerly of the Office of Governor Hassan.

**Jobs for the Future** researched and wrote the report which is aligned with the approach of the first two reports for the manufacturing and technology sectors written by Deborah Kobes. The health care report includes writing by Patricia Maguire; additional research, analysis, and editing by Thomas Hooper and Sara Lamback; editing by Sharron Luttrell; and research, editing, and logistical support by Jessica Toglia.

This report relied heavily on the insights and feedback of a wide variety of New Hampshire stakeholders. We would like to express our appreciation to the health care employers and economic development, workforce, education, and other stakeholders who were interviewed and contributed their time, resources, and expertise. (*See names on next page.*)



**NH Works** promotes life-long learning by partnering with businesses, agencies, and organizations to bring the state's education, employment, and training programs together into a workforce development system that will provide the means for residents of New Hampshire to gain sufficient skills, education, employment, and financial independence.  
[www.nhworks.org](http://www.nhworks.org)



## JOBS FOR THE FUTURE

**Jobs for the Future** (JFF) is a national nonprofit that builds educational and economic opportunity for underserved populations in the United States. We develop innovative career and educational programs and public policies that increase college readiness and career success, and build a more highly skilled workforce. With over 30 years of experience, JFF is the national leader in bridging education and work to increase economic mobility and strengthen our economy.  
[www.jff.org](http://www.jff.org)

- Benjamin Adams, Easter Seals
- Kathy Bizarro-Thurnberg, New Hampshire Hospital Association
- George Copadis, New Hampshire Employment Security
- Helen Cormier, Manchester Community Health
- Sarah Currier, Dartmouth-Hitchcock Hospital
- Dwight Davis, Senior Helpers of the Greater Seacoast
- Eric Dickson, Dartmouth-Hitchcock Hospital
- Chris Dodge, Salem High School
- Alisa Druzba, New Hampshire Department of Health and Human Services
- Robert Duhaime, Catholic Medical Center
- Art Ellison, Adult Basic Education, New Hampshire Department of Education
- Michael Ferrara, University of New Hampshire College of Health and Human Services
- Lynda Goldthwaite, New Hampshire Health Care Association
- Deb Gosselin, Southern New Hampshire Services
- Jim Hinson, New Hampshire Vocational Rehabilitation
- Tom Horgan, New Hampshire College and University Council
- Carolyn Isabelle, Dartmouth-Hitchcock Hospital
- Judy Joy, New Hampshire Nurses Association
- Tamer Koheil, New Hampshire Job Corps Center
- Shawn LaFrance, Foundation for Healthy Communities
- Ellen Lapointe, Ridgewood Center
- Mary Lataurnau, Project Lead the Way
- Paul Leather, Career and Technical Education, New Hampshire Department of Education
- Donnalee Lozeau, Southern New Hampshire Services
- John Malanowski, Dartmouth-Hitchcock Hospital
- Jenny Macaulay, Dartmouth-Hitchcock Hospital
- Jeanne McLaughlin, Visiting Nurse and Hospice of NH and VT
- Katie Mellow, New Hampshire Charitable Foundation
- Samantha O'Neill, Elliot Hospital
- Gene Patnode, New Hampshire Department of Health and Human Services
- Mike Peterson, Androscoggin Valley Hospital
- Ali Rafieymehr, River Valley Community College
- Linda Richelson, River Valley Community College
- Jim Roche, Business Industry Association
- Jeff Rose, New Hampshire Department of Resources and Economic Development
- Nadine Sacco, Dartmouth-Hitchcock Hospital (formerly of the New Hampshire Department of Resources and Economic Development)
- Patricia Shinn, River Valley Community College
- Gregg Solovei, River Valley Community College
- Neil Twitchell, New Hampshire Public Health Association
- Warren West, Littleton Hospital

# PREFACE

This report is part of the New Hampshire Sector Partnerships Initiative (NH SPI), which is a new, industry-driven, statewide initiative to help businesses in targeted industries address their workforce needs, while also helping workers prepare for and advance in careers in these critical sectors. This initiative is initially focusing on four industries: **manufacturing, health care, technology, and hospitality**. These growing and in-demand sectors were selected based upon in-depth discussions with New Hampshire stakeholders regarding high-leverage sectoral opportunities in the state as well as an initial labor market analysis that examined each industry's importance to the New Hampshire economy, its concentration in New Hampshire relative to the country, and the number of middle-skill jobs available in the state that require more than a high-school diploma, but less than a four-year degree.

NH SPI is funded through a United States Department of Labor Sector Partnership National Emergency Grant targeted to assist states in the transition to a Workforce Innovation and Opportunity Act (WIOA) sector partnership approach to workforce development. In New Hampshire, the WIOA service delivery system is managed through a consortium approach known as NH Works.

The [NH Works](#) system consists of the following partner agencies:

- Office of Workforce Opportunity
- New Hampshire Employment Security
- New Hampshire Department of Education
- New Hampshire Vocational Rehabilitation
- New Hampshire Economic Development
- Community Action Agencies of New Hampshire
- Community College System of New Hampshire
- New Hampshire Department of Health and Human Services.

The goal of NH SPI is to assist New Hampshire in connecting the various existing initiatives and build seamless education, career readiness, and training pathways that result in sector strategies that work for all individuals, to create a well-educated populace and a highly-skilled, strong workforce for the region.

NH SPI has contracted with [Jobs for the Future](#) to provide a suite of services to support the success of sector partnerships in New Hampshire, which include labor market analyses, asset mapping, workforce planning, and sector launch events. JFF works nationally to design and scale creative education and workforce strategies that respond to labor market demands.

For this report, JFF collected information from a range of stakeholders to determine assets, challenges, and opportunities to be considered by the state team and health care sector partnership in building, strengthening, and coordinating the education and training pipeline through a sector-driven approach for the health care industry. This report includes recommendations that the state team and sector partnership can use as a starting point for planning and action. JFF will work closely with the state and a team of local leaders with the motivation and “muscle” needed to help them develop and implement a sector partnership action plan.

## STATE OF THE SECTOR

Health care and social assistance is a critical component of the New Hampshire economy: it is the state’s second-largest industry, behind only retail trade, with 76,208 workers in 2015.<sup>1</sup> While the sector has experienced slow but steady growth since 2010, it is projected to grow 11 percent through 2020, signaling that the sector will remain a cornerstone of the state’s economy in the years to come.<sup>2</sup>

The counties with the greatest number of health care jobs are Hillsborough, Rockingham, and Grafton counties, which together account for nearly 70 percent of the state’s health care jobs (Table 1).<sup>3</sup> In Hillsborough county, there are nearly 26,000 health care jobs, more than twice the number in any other county in the state.<sup>4</sup> Overall, the sector is as concentrated in New Hampshire (Figure 1) as in the rest of the nation (LQ is 1.05) with a higher concentration in the state’s northern counties than the Seacoast.

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<sup>1</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

<sup>2</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback. Overall growth in the health care sector was 4 percent from 2010 to 2015.

<sup>3</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback. Hillsborough county accounts for 34 percent of the state’s health care workforce, Rockingham accounts for 19 percent, and Grafton accounts for 15 percent.

<sup>4</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

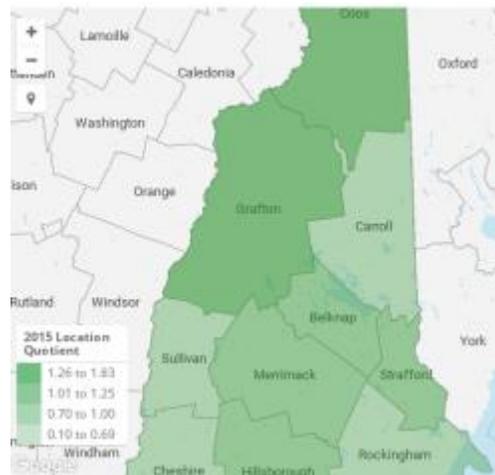
### Location quotient

“*Location quotient*” is the per capita concentration of an industry or occupation in a region as compared with the national average. A value above 1 indicates an above average concentration. The industries highly concentrated in an area are usually critical to the health of its economy and serve as a guide to understanding what makes that area’s labor market unique.

**Table 1: Health Care by Location Quotient<sup>5</sup>**

New Hampshire County	2015 Location Quotient	2015 Jobs
Grafton County	1.83	11,359
Coos County	1.26	1,871
Hillsborough County	1.15	25,894
Strafford County	1.15	6,286
Merrimack County	1.13	9,734
Belknap County	1.02	3,424
Cheshire County	0.93	3,748
Carroll County	0.87	2,389
Rockingham County	0.83	14,253
Sullivan County	0.78	1,406

**Figure 1. Location Quotient of New Hampshire Counties<sup>6</sup>**



<sup>5</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

<sup>6</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

The health care sector includes three major industries: ambulatory health care services, hospitals, and nursing and residential care facilities, each of which includes distinct types of facilities:<sup>7</sup>

- **Ambulatory health care services:** provide outpatient services directly or indirectly to patients (e.g., offices of dentists, medical and diagnostic laboratories)
- **Hospitals:** provide medical, diagnostic, and treatment services to inpatients—and, in some cases outpatients (e.g., general medical and surgical hospitals, psychiatric and substance abuse hospitals)
- **Nursing and residential care facilities:** offer residential care in conjunction with nursing, supervision, or other types of care which typically includes both health and social services (e.g., community care facilities for the elderly, nursing care facilities)

The greatest number of jobs in New Hampshire’s health care sector is in ambulatory health care services and hospitals (Table 2). Despite the fact that there are more statewide jobs in ambulatory health care services, the state has a particularly strong hospital subsector, which is significantly more concentrated (nearly 30 percent) in New Hampshire than the nation (LQ of 1.30).<sup>8</sup> Median annual earnings vary widely across the subsectors and earnings within the nursing and residential care subsector (\$39,074) lag significantly behind those in both ambulatory health care (\$83,939) and hospitals (\$70,181).<sup>9</sup>

Current employer demand is strong in the health care sector, based upon both discussions with health care employers and real-time job posting data. There were over 24,000 job postings for the health care and social assistance sector in 2016, which represented the greatest number of any sector in the state and suggests that there is likely unmet need for workers in the sector.<sup>10</sup> Further, each subsector is projected to experience strong growth through 2020, with anticipated growth in ambulatory health care services at 13 percent, nursing and residential care facilities at 11 percent, and hospitals at 9 percent.

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<sup>7</sup> Subsector descriptions are adapted directly from the Bureau of Labor Statistics. 2016. “Industries at a Glance.” Accessible at: <https://www.bls.gov/iag/tgs/iag621.htm#about>

<sup>8</sup> Note on LQ: An LQ of 1.0 indicates that an industry is as concentrated in the target region as in the nation. An LQ of 1.20 indicates a concentration 20 percent higher than that of the nation. The LQ for ambulatory health care is 0.98 and the LQ for nursing and residential care is 1.01. The overall LQ for the sector includes both health care and social assistance (NAICS 62). Source: Emsi Analyst. 2016.4 data extracted by S. Lamback.

<sup>9</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback. Note: government-owned hospitals (e.g., V.A. facilities) are included in these data.

<sup>10</sup> Burning Glass Technologies. Labor/Insight. Data for the state of New Hampshire for the full year of 2016 by industry sector, extracted by S. Lamback.

**Table 2: Distribution of Jobs by Health Care Subsectors<sup>11</sup>**

NAICS	Description	2015 Jobs	2015 Establishments
621	Ambulatory Health Care Services	37,421	2,402
622	Hospitals	28,276	43
623	Nursing and Residential Care Facilities	15,068	333

During interviews and focus groups, many of the state’s health care employers reported experiencing a “skills gap,” and having difficulty finding qualified people at all levels, including hospitality positions, medical assistants, home health aides, primary care physicians, and mental health clinicians. For the higher skilled occupations, employers have turned to telemedicine and telepsychiatry to help meet New Hampshire residents’ health care needs. The most dominant occupations though in New Hampshire’s health care sector are inpatient care, with registered nurses, nursing assistants, and personal care aides together accounting for nearly 40 percent of workers employed within the sector (Table 4), and typically require in-person staff. Non-patient care roles such as receptionists and medical secretaries also play an important role in the sector and can offer effective entry points into the sector. Of the top 10 occupations in the sector, only three require a bachelor’s degree or higher and several require a postsecondary credential, signaling that there are strong middle-skill opportunities within the sector. Overall, approximately 64 percent of jobs in the sector require some type of postsecondary degree or credential.<sup>12</sup>

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<sup>11</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

<sup>12</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback. Occupations with fewer than 10 individuals employed statewide were excluded from this analysis.

**Table 3: Top Health Care Occupations in New Hampshire, based upon Employment<sup>13</sup>**

SOC	Description	2015 Jobs	Median Hourly Earnings	2015 Location Quotient	Regional Completions (2013)	Annual Openings	Typical Entry Level-Education
29-1141	Registered Nurses	13,194	\$31.35	1.02	932	604	Bachelor's degree
31-1014	Nursing Assistants	8,985	\$13.87	1.31	118	362	Postsecondary non-degree award
39-9021	Personal Care Aides	8,206	\$11.01	0.87	2	286	No formal ed./credential
43-4171	Receptionists and Information Clerks	5,743	\$13.93	1.16	0	226	High school diploma or equivalent
29-1069	Physicians and Surgeons, All Other	2,464	\$100.30	1.25	128	114	Doctoral/prof. degree
43-6013	Medical Secretaries	2,383	\$16.80	0.94	108	81	High school diploma or equivalent
31-9092	Medical Assistants	2,380	\$16.25	0.85	508	117	Postsecondary non-degree award
29-2061	Licensed Practical and Licensed Vocational Nurses	2,363	\$22.64	0.69	109	120	Postsecondary non-degree award
31-1011	Home Health Aides	2,348	\$12.35	0.46	27	167	No formal ed./credential
19-3031	Clinical, Counseling, and School Psychologists	1,834	\$37.33	1.15	969	76	Doctoral/prof. degree

<sup>13</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

The health care sector currently faces several challenges. New Hampshire's seasonally adjusted unemployment was at 2.8 percent statewide in October, 2016, indicating a tight job market.<sup>14</sup> While beneficial to workers, this low unemployment rate can pose a challenge for the state's employers. For example, in focus groups and interviews, employers unanimously cited the low unemployment rate as one of their biggest recruitment challenges. With communities almost at full employment, there is a very small recruitment pool from which to select employees. When you add the need for skills, credentials, and work experience, the pool dwindles even further.

At the same time, the state's aging population, sometimes termed a "silver tsunami," will further decrease the supply of available workers as the baby boom generation retires. In the health care sector, this challenge is particularly pronounced as approximately 27 percent of the health care workforce is 55 years old or older.<sup>15</sup> In the coming years, the aging workforce will not only decrease the workforce, but also potentially increase the overall demand for health care services across the state. New Hampshire employment projections for 2014 to 2024 estimate that the state will add 5,913 new jobs in health care practitioner and technical occupations, and 3,424 new jobs in health care support occupations. Annually, 2,146 job openings are projected for workers in these two groups, 1,207 of which are expected to be due to replacement of workers leaving the occupation, thus further compounding the health care skills gap.<sup>16</sup>

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<sup>14</sup> U.S. Department of Labor. October 2016. Bureau of Labor Statistics. "Seasonally adjusted statewide unemployment rate for New Hampshire." Accessed at: <https://data.bls.gov/cgi-bin/dsrv>

<sup>15</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

<sup>16</sup> New Hampshire Employment Security, Economic and Labor Market Information Bureau. September 2016. "Health Care Workers in New Hampshire: A Snapshot of the Health Care Industry and Health Care Workers." Available at: <http://www.nhes.nh.gov/elmi/products/documents/sp-health-care-article.pdf>. Note: projections of employment for health care-related workers include those employed at both privately owned and government-owned facilities.

# KEY AREAS OF FOCUS: ASSETS AND RECOMMENDATIONS

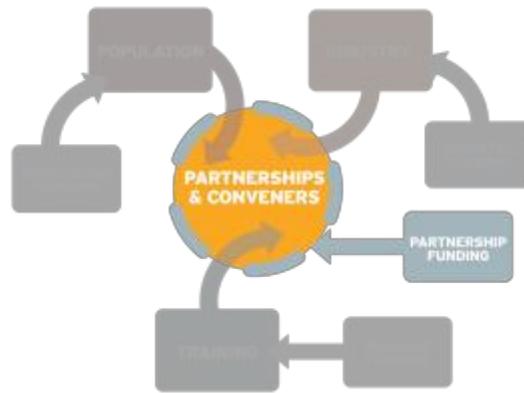
Within the different health care subsectors, there are strong, yet disconnected examples of collaboration already occurring. The disconnection is not intentional, but has occurred due to the fact that until recently there has not been a major catalyst for convening across the whole sector. For instance, the New Hampshire Hospital Association, the New Hampshire Nursing Association, and the New Hampshire Health Care Association are strong industry intermediaries, but their missions are to convene and advocate for their membership. However, all industry interviewees acknowledge the need to band together across the entire state and sector in order to address the significant existing and looming workforce needs of the New Hampshire health care sector and collectively work on education and workforce solutions. No one association, subsector, or employer can do it alone. Currently, there is considerable appetite across all interviewees to develop a statewide, industry-led sector partnership that can leverage the state's and sector's many existing assets, resources, programs, and partnerships (Table 4) to meet the health care sector's vital workforce needs.

This report outlines key issues and provides recommendations for consideration as New Hampshire takes the critical next steps to launching a sector partnership. It examines priority challenges and opportunities identified by a range of key health care leaders representing business, education and training providers, the workforce system, policymakers, and other critical partners. A key theme across all highlighted topics is the need for health care stakeholders to connect across health care subsectors and build consensus around needs that are common to employers in all subsectors, in order to develop workforce solutions that incorporate hospitals, residential and long-term care, as well as ambulatory services. This report offers four broad recommendations:

1. Develop an actionable assessment of workforce needs across subsectors
2. Expand career pathways that cross subsectors and include more entry points, work-based learning, financial and non-financial supports and incentives
3. Expand recruiting efforts to non-traditional populations
4. Connect to economic and community development efforts
5. Advocate for state legislative and administrative policies to support health care workforce

**Table 4: Summary of Major Assets for the Health Care Talent Pipeline**





## PARTNERSHIPS AND CONVENERS

### Statewide Economic Development

- NH Department of Resources and Economic Development/Division of Economic Development
- Office of Workforce Opportunity/NH Works
- NH Works Interagency Business Team (IBT)
- NH State Workforce Innovation Board
- NH Coalition for Business and Education (NHCBE)
- 65 by 25, Community College System of NH (CCSNH)
- Guided Pathways
- Business and Industry Association (BIA)
- Stay Work Play
- Live Free and Start
- NH Association of Career and Technical Administrators (NHCTA)
- Career and Technical Student Organizations (CTSO)
- I4see (Initiative for School Empowerment and Excellence)

### Statewide Health Care Specific

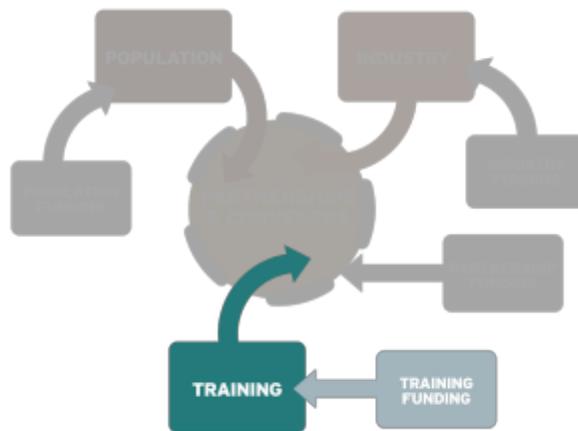
- The Governor’s Commission on Health Care and Community Support Workforce
- NH Citizens Health Initiative
- New England Alliance for Health
- Foundation for Healthy Communities
- New Hampshire Health Care Association
- New Hampshire Nursing Association
- New Hampshire Hospital Association
- University of NH College of Health and Human Services

### Regional

- North Country Health Consortium
- STEAM Ahead NH
- River Valley Workforce Institute
- Industrial Development Corporations
- 10 Regional Development Corporations
- Chambers of Commerce

### Partnership Funding

- NH Charitable Foundation
- Federal Apprenticeship Planning/Accelerator Grant
- Federal Apprenticeship Expansion Grant
- Workforce Innovation and Opportunity Act (WIOA)



## TECHNICAL TRAINING

### K-12 and CTE

- Running Start
- New Skills for Youth
- School-to-Work NH
- eStart
- Southern New Hampshire University in the High School
- Project Lead the Way® Curriculum

### CTE (Career Technical Education)

#### Health Professions & Related Services:

- Berlin Regional Career and Technology Center (Berlin, NH)
- Cheshire Career Center (Keene, NH)
- Concord Regional Technology Center (Concord, NH)
- Creteau Regional Technology Center (Rochester, NH)
- Dover Career Technical Center (Dover, NH)
- Hartford Area Career & Technology Center (White River Junction, VT)
- Hugh J. Gallen Regional Career & Technical Education Center (Littleton, NH)
- J. Oliva Huot Technical Center (Laconia, NH)
- Lakes Region Technology Center (Wolfeboro, NH)
- Manchester School of Technology (Manchester, NH)
- Milford High School and Applied Technology Center (Milford, NH)
- Mt. Washington Valley Career and Technical Center (Conway, NH)
- Nashua Technology Center (Nashua, NH)
- Pinkerton Academy (Derry, NH)
- Plymouth Applied Technology Center (Plymouth, NH)
- River Bend Career and Technical Center (Bradford, VT)
- River Valley Technical Center (Springfield, VT)
- Salem Career & Technical Education Center (Salem, NH)
- Seacoast School of Technology (Exeter, NH)
- Sugar River Valley Regional Technical Center – Newport (Newport, NH)
- Wilbur H. Palmer Vocational Technology Center (Hudson, NH)

## TECHNICAL TRAINING (continued)

### Health and Wellness:

- River Valley Technical Center (Springfield, VT)

### Family and Community Services

- River Valley Technical Center (Springfield, VT)
- Hartford Area Career & Technology Center (White River Junction, VT)
  - Pre-Medicine/Pre-Medical Studies
  - Hartford Area Career & Technology Center (White River Junction, VT)

## Community College System of NH (CCSNH)

### Allied Health, Nursing and Wellness:

- Great Bay Community College
  - Associate degrees in Nursing, Surgical Technology, Veterinary Technology
  - Certificates in Health Information Technology, Massage/Therapeutic Massage, Medical Administrative Assistant, Veterinary Technology
- Lakes Region Community College:
  - Associate degrees in Health Information Technology, Nursing, Nursing – Advanced Placement Program
  - Certificates in Gerontology, Medical Administrative Assistant
- Manchester Community College:
  - Associate degrees in Exercise Science, Health Information Management, Health Science, Medical Assistant, Nursing, Nursing – Advanced Placement Program
  - Certificates in Medical Administrative Assistant, Medical Coding, Personal Training, Phlebotomy
- Nashua Community College:
  - Associate degrees in Massage/Holistic Massage Therapy, Nursing, Nursing – Advanced Placement, Speech-Language Pathology Assistant
  - Certificates in Massage/Holistic Massage Therapy
- New Hampshire Technical Institute-Concord:
  - Associate degrees in Dental Hygiene, Health Science, Nursing, Nursing – Advanced Placement Program, Orthopedic Technology, Paramedic Emergency Medicine, Radiation Therapy, Radiologic Technology
  - Certificates in Coaching, Dental Assisting, Diagnostic Medical Sonography, Legal Nurse Consultant, Medical Coding, Orthopedic Technology, Radiation Therapy
- River Valley Community College:
  - Associate degrees in Cyber Security & Health Care IT, Health Information Management, Medical Laboratory Technician, Nursing, Nursing – Advanced Placement Program, Occupational Therapy Assistant, Physical Therapy Assistant, Radiography, Respiratory Therapy
  - Certificates in Cyber Security & Health Care IT, Massage/Holistic Massage Therapy, Medical Administrative Assistant, Medical Assistant, Phlebotomy
- White Mountains Community College:
  - Associate degrees in Health and Wellness Facilitator, Health Science, Medical Administrative Assistant, Medical Assistant, Nursing
  - Certificates in Cybersecurity and Health Care IT, Health and Wellness Advocate, Health and Wellness Coach, Massage/Holistic Massage Therapy, Medical Coding, Phlebotomy

## TECHNICAL TRAINING (continued)

### Four-Year Colleges

- University of New Hampshire:
  - Bachelor of Science degrees in Communication Sciences and Disorders, Health Management & Policy, Human Development and Family Studies, Kinesiology with concentrations in Athletic Training, Exercise Science, Outdoor Education, Health and Physical Education, Sport Studies, Nursing, Occupational Therapy, Recreation Management & Policy: Program & Event Management and Therapeutic Recreation, Social Work
  - Minors in Deaf and Hard of Hearing Studies, Public Health, Adolescent and Youth Development, Child Life Curriculum, Human Development and Family Studies, Kinesiology, Coaching, Applied Human Anatomy & Physiology, Interdisciplinary Health, Interdisciplinary Disabilities Studies, Child Life, Gerontology, Tourism Management, Social Work
  - Master of Science degrees in Communication Sciences and Disorders, Public Health, Health Management, Marriage and Family Therapy, Core Areas of Study in either Child Development or Adolescent Development, Kinesiology: Exercise Science, Outdoor Education, Sports Education, Nursing: Clinical Nurse Leader, Evidenced Based Nursing, Family Nurse Practitioner, Occupational Therapy, Recreation Management & Policy, Masters of Social Work
  - Graduate Certificates in Public Health, Adolescent Development, Physical Education, Post-Master's Family Nurse Practitioner, Post-Master's Psychiatric Mental Health Nurse Practitioner
  - PhD in Outdoor Education/Experiential, Nursing Practice
- Keene State College:
  - Bachelor of Science degrees in Health Science (Health Promotion, Nutrition, Addictions), Nursing, Physical Education & Athletic Training, Psychology, Sociology, Safety & Occupational Health Applied Science
- Dartmouth College:
  - Bachelor of Science degrees in Psychological and Brain Sciences, Sociology
  - Master of Health Care Delivery Service, Master of Science in Health Policy and Clinical Practice
  - Doctoral programs in Health Policy and Clinical Practice, Psychological and Brain Sciences
- Granite State College:
  - Associate of Science degree in Behavioral Sciences
  - Bachelor of Science degrees in Health Care Management, Human Services, Psychology, Social Science, Allied Health Leadership, Applied Studies – Human Services and Early Childhood Development, Health Information Management, Health and Wellness, Nursing
- Southern New Hampshire University:
  - Associate of Science Degree in
  - Bachelor of Art Degree in Community Health
  - Bachelor of Science Degrees in Health Information Management, Business Administration – Health Care Administration, Community Health Education, Health Sciences, Health Care Administration, Health Care Administration – Health Information Management, Health Care Administration - Patient Safety and Quality, Nursing – RN to BSN, Nursing – RN to BSN – Accelerated RN to MSN
  - Master of Nursing in Nursing, Nursing – Educator, Nursing – Clinical Nurse Leader, Nursing – Patient Safety and Quality
  - Master of Science in Health Information Management, Health Care Administration, Information Technology – Health Care Informatics, Management – Health Care, Public Health
  - Master of Business Administration in Health Care Informatics, Health Care Management

## TECHNICAL TRAINING (continued)

### Four-Year Colleges (continued)

- Rivier University:
  - Associate of Science in Nursing
  - Bachelor of Science degrees in Nursing, Public Health
  - Bachelor of Art degrees in Human Development, Psychology
  - Master of Business Administration in Health Care Administration
  - Master's degrees in Clinical Mental Health Counseling, Counseling, School Psychology, Clinical Psychology, Experimental Psychology, Public Health
  - Master of Nursing degrees in Advanced Practice RN Degree Completion, Family Nurse Practitioner, Nursing Education, Leadership in Health Systems Management, Psychiatric/Mental Health Nurse Practitioner
  - Post-Master's Nursing Certificates in Family Nurse Practitioner, Nursing Education, Psychiatric Mental Health Nursing
  - Doctor of Nursing Practice, Doctor of Psychology

### Employer-led

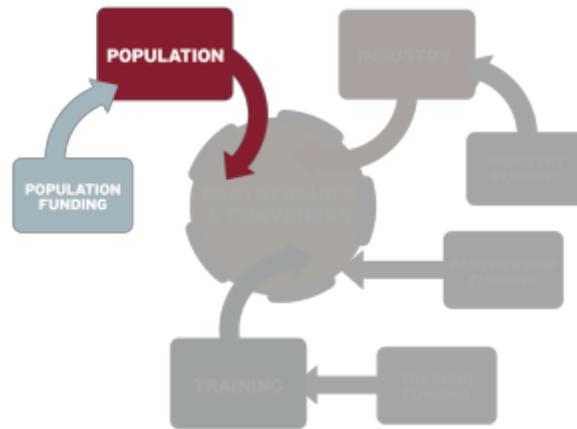
- Elliot Health System's New England EMS Institute
- Dartmouth-Hitchcock's Workforce Readiness Institute
- Pre-Apprenticeships
- Registered Apprenticeships (including sponsored by other entities including NH Department of Education)
- On-the-Job Training

### Other

- Southern New Hampshire Services' On-the-Job-Training Program
- NH Job Corps - Manchester
- 10,000 Mentors
- National Governors Association Work-Based Learning Initiative
- Workplace Success Program
- Northern Area Health Education Center (AHEC)
- Southern Area Health Education Center (AHEC)
- American Red Cross Licensed Nurse Assistant (LNA) Training
- Home Care University (e-learning affiliate of National Association for Home Care & Hospice)

### Training Funding

- NH Health Profession Opportunity Project (HPOP)
- Office of Workforce Opportunity
- Company benefits: tuition reimbursement
- Department of Labor National Emergency Grants
- National Science Foundation (NSF) Advanced Technical Education
- NSF (for UNH K-12 teacher training)
- ApprenticeshipUSA State Accelerator Grant
- ApprenticeshipUSA State Expansion Grants (awarded 10/21/2016)
- Housing & Urban Development (HUD) Community Development Block Grant
- NH Department of Education English Language Learner Training for Employers
- PETAC grants
- New Skills for Youth Grant



## TARGET POPULATIONS

### Unemployed and Underemployed

- WorkReadyNH
- NH Works Career Centers

### Veterans

- NH Employment Security Veterans Representatives (services for vets and their families)
- Department of Veterans Affairs
- U.S. Department of Labor (DOL) Veterans' Employment and Training Service
- NH Employer Support of the Guard and Reserve (Concord)

### Women

- Center for Women's Business Advancement
- Center for Women and Enterprise

### Immigrants and Refugees

- NH Refugee Program (U.S. HHS Office of Refugee Resettlement)
- Southern New Hampshire Services, English for New Americans
- Ascentria Care Alliance
- International Institute of New Hampshire
- Concord Multicultural Project
- Laconia Human Relations Committee

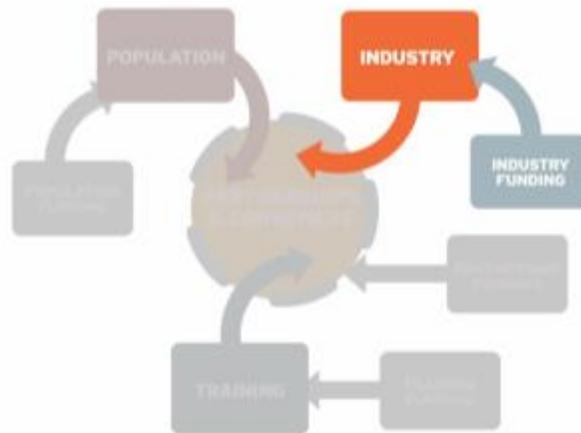
### People with Disabilities

- State Vocational Rehabilitation agency
- Easter Seals
- Goodwill Industries
- Work Opportunity Unlimited
- HHS ServiceLink Aging & Disability Resource Center
- The Moore Center

## TARGET POPULATIONS (continued)

### Population Funding

- Pell grants (and other federal student aid)
- Medallion fund of NH Charitable Foundation
- U.S. Department of Labor Workforce Innovation & Opportunity Act (WIOA) Adult, Dislocated Worker, and Youth Funds
- U.S. Department of Agriculture Supplemental Nutrition Assistance Program, Employment and Training
- U.S. Department of Health and Human Service Temporary Assistance for Needy Families
- Return to Work
- NH Women's Foundation U.S. Department of Veteran's Affairs, Education and Training Benefits and Programs
- NH Scholar Program
- Charitable Foundation STEM Scholarship Fund



## INDUSTRY

- Human Resources Groups - local and national (Society for Human Resource Management)
- New Hampshire Health Care Association
- New Hampshire Nursing Association
- New Hampshire Hospital Association

### Industry Funding

- Community Development Finance Authority (CDFA)

## OTHER RESOURCES

- BIA Strategic Economic Plan for NH
- NH Division of Economic Development Strategic Plan
- WIOA State Plan

## **1) DEVELOP AN ACTIONABLE ASSESSMENT OF WORKFORCE NEEDS ACROSS SUBSECTORS**

The theme that emerged most frequently across all health care employers interviewed was the need for a qualified, sustainable workforce and a strong worker advancement pipeline. Also prevalent was the concern that while the current staffing needs are troubling, even more so are those in the near future, three to five years. The workforce and education stakeholders interviewed stressed the need for an honest and aggregate assessment of the skills, credentials, and occupations in demand. There appears to be some disconnect in terms of supply and demand, for example, while employers cited the need for licensed nursing assistants (LNAs), educators noted having to close LNA programs due to low demand and not being able to fill classrooms. A collective approach among health care employers will help facilitate communication and collaboration with education and workforce stakeholders.

### **Assets**

The good news is that the awareness of the increasing demand in health care is shared across all subsector employers as well as the willingness and openness to partner with other employers and education and training stakeholders. There is appetite to be creative and develop innovative solutions. There are also very strong industry associations that advocate for their membership, including the New Hampshire Hospital Association, the New Hampshire Health Care Association, and the New Hampshire Nursing Association. Both the Hospital and Nursing Associations have members on former Governor Hassan's Commission on Health Care and Community Support Workforce. The Health Care Association has dedicated a Committee focused on identifying the education and training needs of residential care providers' staff.

In addition, there are regional collaborative efforts underway such as the North Country Health Consortium (NCHC). Health care employers and stakeholders in the North Country recognized the need to come together to identify and solve common problems. Thus, they began convening in 1997 to create a rural health network "to improve the health status of the region."<sup>17</sup> There is great opportunity to connect all these individual efforts in a statewide partnership, while still retaining regional diversity and leadership. A coordinated effort has greater potential to address the major health care workforce challenges that the whole state is feeling now as well as those looming in the near future.

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<sup>17</sup> About North Country Health Consortium: Mission. Nd. Accessible at: [http://www.nchcnh.org/NCHC\\_about.php](http://www.nchcnh.org/NCHC_about.php)

The New Hampshire Department of Health and Human Services (DHHS) and the Economic and Labor Market Information (ELMI) Bureau are also significant resources. Both collect and analyze data from the health care sector that could be leveraged to further define the occupations, skills, and credentials employers need in an actionable way for education and training partners as they design and/or redesign curriculum and programs.

## **Strategic Recommendations**

### ***Identify common skill sets across subsectors for critical middle skill occupations.***

Although the subsectors possess unique environments, the job functions and skill sets needed are common across all of them, signaling that a shared approach could benefit all by creating pathways to and from the subsectors and addressing their shared recruitment and retention challenges. For example, health care employers in all three industries are struggling to find qualified applicants to fill open middle skill positions such as medical assistants and home health care roles, both of which are experiencing increased demands related to scope of responsibility and quality of care. One employer noted that there is no such thing as “just a medical assistant.” Middle skill positions are taking on more nonclinical responsibilities such as coordination, management, and marketing and outreach functions.

If health care employers from all industries work together to identify the top skills and certifications that are needed, this can be aggregated and integrated into academic and training programs to ensure students are being adequately prepared and graduate with competencies in both clinical and nonclinical areas.

Based upon an analysis of real-time labor market information, the skills in the chart below emerged as most critical across the sector.<sup>18</sup> These skills were vetted by JFF through discussions with employers, who underscored in particular, the growing importance of nonclinical competencies such as management, communication, and technology skills.

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<sup>18</sup> Burning Glass Technologies, Labor/Insight. Parameters: New Hampshire statewide data for the health care industry over the last 12 months. Findings are based upon 11,910 total job postings, though 3,684 postings were excluded because they did not have specific skills listed and 6,548 postings were excluded because they were lacking certification information.

**Table 6: Critical Health Care Skills**

Specialized Skills	Baseline skills
Patient Care	Communication Skills
Treatment Planning	Team Work/Collaboration
Cardiopulmonary Resuscitation	Computer Skills
Rehabilitation	English
Physical Therapy	Organizational Skills
Software/Programming Skills	Top Certifications
Microsoft Office Suite	First Aid CPR
Pointclickcare <sup>19</sup>	Basic Cardiac Life Support
ICD-9-CM Coding	American Physical Therapy Association
SharePoint	National Board Certification in Occupational Therapy
HCPCS Coding	

**Develop a focused effort on needed computer and management competencies across occupations.** As mentioned previously, nonclinical skills are in high demand based on data culled from job openings, but this came through as even more relevant in employer interviews and focus groups in two key areas: computer and management competencies. Employers cited the changing nature of health care due to the Affordable Care Act (ACA), with a team-based model of coordinated care and the increased use of technology in the field as key drivers. Traditionally, though, health care training and degree programs focus on the clinical competencies of roles.

Patient care now requires more organization and a flow coordinator to manage care. With the growing shift to health care services provided in the community and in the home, coordination extends across hospitals, community health centers, long-term care facilities, and patients' homes. In rural areas, this need is even more prevalent as employers report lean operations and increased staff roles and responsibilities.

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<sup>19</sup> PointClickCare is a type of cloud-based software for the senior-care industry.

Health care employers also reported that they need employees in most occupational levels who have a strong level of computer literacy since many employees are expected to utilize Microsoft Office and data entry systems. An even higher level of computer literacy that includes critical thinking, troubleshooting, and systems thinking is highly valued and sought after by employers. There is opportunity to partner with the New Hampshire Technology Talent Partnership and leverage existing computer and technology training programs and curriculums and add a contextualized health care component.

***Prioritize developing the nursing pipeline particularly in long-term care.*** The United States has a nursing shortage and will need not just more nurses, but BSNs. The Institute of Medicine's goal of having 80 percent bachelor-degreed nurses by the year 2020, cites lower rates of mortality and medical errors associated with the use of BSNs.<sup>20</sup> All New Hampshire employers stressed the need to address the current and future nursing shortage. The demand for qualified nurses is felt across all levels; licensed nursing assistants through baccalaureate-prepared nurses, and nurses with master's degrees and above are needed as nursing faculty.

This need was particularly acute in long-term care which competes with hospitals' higher salaries and the lack of awareness of the opportunities in this subsector. To meet the current need, long-term care employers are utilizing staffing agencies to fill positions. This temporary fix has not only significant financial implications, but costs associated with providing quality patient care. Long-term care providers want full-time nurses who will provide a stable, quality level of care to patients and felt that temporary nurses just do not possess the same level of commitment and dedication.

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<sup>20</sup> Institute of Medicine of the National Academies. 2010. "The Future of Nursing: Leading Change, Advancing Health." Available at: <https://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Recommendations.pdf>.

## **2) EXPAND CAREER PATHWAYS THAT CROSS SUBSECTORS AND INCLUDE MORE ENTRY POINTS, WORK-BASED LEARNING, FINANCIAL AND NON-FINANCIAL SUPPORTS AND INCENTIVES**

Many interviewees noted that the ACA changed the way health care is delivered, gravitating toward a team model of patient care as well as moving health care into the homes and the communities. What has not changed though, is the way the health care workforce is educated. As previously stated, approximately 64 percent of jobs in the sector require some type of postsecondary degree or credential, suggesting there is an opportunity to better link entry-level jobs with postsecondary education and training for incumbent workers to help facilitate advancement along career pathways and to employers to fill higher skill positions.<sup>21</sup> While there are occupations and skill sets that are common across the health care subsectors, there is a training/retraining need when transitioning to and from these different settings. Developing cross-subsectors career pathways and work-based learning opportunities with appropriate supports and incentives can go a long way to addressing this challenge and need.

### **Assets**

Career pathways are a valuable tool to connect multiple occupations and levels of education and training on a pathway with multiple on- and off-ramps and create a talent pipeline. For example, the Institute on Assets and Social Policy, in partnership with the New Hampshire Office of Minority Health and Refugee Affairs, developed a health care pathway that begins with licensed nursing assistant and advances to licensed practical nurse, registered nurse, and bachelor of science in nursing and includes additional entry points.<sup>22</sup>

New Hampshire has many great examples of career pathways programs and work-based learning opportunities (Appendix 2), including Registered Apprenticeships, but on a small scale. Interviewees noted that health care-focused registered apprenticeship programs have a foothold in New Hampshire, but are not widespread. Recent apprenticeship grants have been awarded to New Hampshire that are a huge asset that should be leveraged to expand health care apprenticeships. This includes the ApprenticeshipUSA Accelerator Grant and the ApprenticeshipUSA Expansion grant led by the Community College System of New Hampshire (CCSNH), which seeks to further the flexible, competency-based model that includes both pre-

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<sup>21</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback. Occupations with fewer than 10 individuals employed statewide were excluded from this analysis.

<sup>22</sup> Institute on Assets and Social Policy. 2014. "Strengthening New Hampshire's Health Care Workforce: Strategies for Employers and Workforce Development Leaders." Available at: <https://iasp.brandeis.edu/pdfs/2014/Workforce.pdf>.

apprenticeship and registered apprenticeship training in advancement manufacturing, information technology, and health care.<sup>23</sup>

65 by 25: Achieving Economic Prosperity Through Post-Secondary Education is another statewide initiative led by CCSNH to leverage for the health care sector. It has a “goal to help ensure that 65 percent of adults 25 and older in New Hampshire will have some form of post-secondary education, from certificates to advanced degrees, by 2025.”<sup>24</sup>

There are a variety of science, technology, engineering, and math (STEM) efforts in New Hampshire that the New Hampshire health care partnership should connect with including the Governor’s STEM Taskforce.<sup>25</sup>

New Hampshire’s community colleges do a good job of providing health care-focused education and training. A noted best practice is the partnership between Great Bay Community College, Exeter Hospital’s primary and specialty care affiliate Core Physicians, and Wentworth-Douglass Hospital on a new, accelerated medical assistant training program. This registered apprenticeship program incorporates incentives for students which include having 60 percent of tuition paid when hired by Core Physicians and receiving base pay and benefits during the program.<sup>26</sup> The CCSNH is an asset to scale these types of partnerships with individual community colleges.

Other strengths and resources include underutilized New Hampshire community development block grant (CDBG) funds that could be a source of health care training dollars and Trade Adjustment Assistance Community College Career Training (TAACCCT) grants making investments in health care (contextualized curriculums, accelerated pathways).

## Strategic Recommendations

**Create additional entry points to career pathways.** JFF recommends expanding awareness and access to existing career pathways, especially among those in entry-level positions. One potential strategy to increase the supply for patient care roles is to develop career pathways that bridge entry-level nonpatient care and nursing and help employers meet their demand for nurses. This would help fill current openings as well as create a pipeline of

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<sup>23</sup> New Hampshire High Tech Council. April 2015. “Re: That American Apprenticeship Initiative Opportunity.” Available at: <https://nhhtc.org/re-that-american-apprenticeship-initiative-opportunity/>.

<sup>24</sup> Community College System of New Hampshire. n.d. “65 By 25: Achieving Economic Prosperity Through Post-Secondary Education.” Available at: <http://www.ccsnh.edu/65by25>.

<sup>25</sup> New Hampshire Department of Education. n.d. “Governor’s Science, Technology, Engineering and Math Education Task Force.” Available at: <http://www.education.nh.gov/instruction/stem/governors-task-force.htm>.

<sup>26</sup> Seacoast Online. May 2015. “Great Bay Launches New Medical Assistant Program. Available at: <http://www.fosters.com/article/20150526/NEWS/150529761?start=2>.

workers, but does represent a culture change and would require buy-in from the managers of these departments.

Many health care employers expressed challenges in filling roles in housekeeping, janitorial, environmental, cooks, and other hospitality-related positions. Employers are not able to retain workers in these departments as they have previously, thus there is the need to think outside the box to recruit for these positions. Another challenge for these positions is that they pay lower wages (\$10-\$14 an hour). Although the prevalence of these types of positions in the health care sector may not be overwhelmingly high (maids and housekeeping are 1.7 percent of workers; janitors and cleaners, 0.9 percent; and cooks, institutional and cafeteria, 0.7 percent), they represent a workforce challenge and an opportunity.<sup>27</sup> Typically, these occupations require no formal education requirements. Thus, they could be an ideal entry point on a career pathway for jobseekers where they could obtain paid work experience as well as supportive services to enable them to seek the next educational level, whether it be a high school equivalency, postsecondary certificate, and/or associate's degree.

For example, Dartmouth-Hitchcock is considering expanding its medical assistant career pathway to allow housekeeping and hospitality roles as additional entry points. A potential scenario would be having high school graduates enter these jobs for a short period of two years, and receive financial and nonfinancial support from the hospital to obtain more training and education to advance to higher levels.

***Expand and support work-based learning opportunities (WBL).*** WBL includes job shadowing, internships, and apprenticeships and is a structured approach to providing instruction and training in the workplace. Employers noted the need for an onboarding period for program graduates and depending on capacity, offered varying lengths of time for such efforts. New Hampshire has many apprenticeship models and resources noted in the assets section that could be utilized to address this challenge. Some employers, such as Dartmouth-Hitchcock, have successfully utilized Workforce Innovation and Opportunity Act (WIOA) on-the-job-training (OJT) funds, but overall use of OJTs in health care across the state have declined. Increasing utilization of these funds could provide a chance to recruit workers and build skills at minimal cost to the employer.

***Develop accelerated career pathways for incumbent workers that include incentives for advancement.*** Financial and time costs are major barriers for incumbent workers seeking additional training and education to advance in their careers. Linking programs together in a streamlined pathway can significantly decrease time and costs. For instance,

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<sup>27</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback. Occupations with fewer than 10 individuals employed statewide were excluded from this analysis.

short-term certificates can stack toward the completion of an associate's degree and then a bachelor's degree, eliminating any unnecessary duplication of classes and credits. This also includes looking at existing programs, such as the Dartmouth-Hitchcock registered apprenticeship model and working with a postsecondary institution to develop an articulation agreement that issues credits for program completion. Prior learning assessment is another avenue to explore for expediting incumbent worker progression. The Council on Adult & Experiential Learning (CAEL) has standards for assessing learning that could be useful.<sup>28</sup>

Both financial and nonfinancial supports are crucial to set incumbent workers up for success. The New Jersey New Paths to Professional Nursing project found that employer commitment to workers' advancements is just as crucial as financial supports to working students' success. Success is more likely when the senior leadership of the health care employer is committed as well as the employee's supervisor and peers. Committed employers offer mentorship programs, flexible scheduling around academic schedules, coaching, and emotional supports.

***Expand employer tuition assistance and state loan repayment programs.*** The cost of education is a major barrier both for new entrants into the field as well as for existing health care workers who want the education and training necessary to advance their careers. Costs include tuition plus a variety of expenses such as clinical fees, books, child care, transportation, etc. Most health care employers have some form of tuition assistance, but it is limited and underutilized. Also, many tuition assistance policies require employees to pay costs up front and then get reimbursed. This assumes the employee has the money to cover costs, which is not always the case. Additionally, sometimes employer tuition assistance/reimbursement only applies to courses toward degree programs. Expanding these policies to include certificate programs and noncredit bearing courses for in-demand occupations could begin to address employers' workforce needs.

The New Hampshire Department of Health and Human Services has a loan repayment program in collaboration with the New Hampshire Vermont Recruitment Center, a service of the Bi-State Primary Care Association. Unfortunately, the loan repayment program has limited resources and also typically does not extend benefits to postsecondary debt for entry and middle skill occupations. The agency should consider updating its policy to meet industry needs in high-demand occupations.

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<sup>28</sup> Council for Adult and Experiential Learning. Nd. Available at: <http://www.cael.org/higher-education/prior-learning-assessment-services>.

Children’s Hospital Boston, in partnership with the Health Care Training Institute (a workforce partnership led by JVS Boston), has tackled a similar barrier and piloted a policy where the hospital pays tuition in advance and the policy targets high-growth, high-demand certificates and degrees.<sup>29</sup> The NH Health Care Partnership should work to expand and strengthen tuition assistance and loan repayment programs in order to remove or at least lessen the financial barrier for students and workers to seek post-secondary training in the health care field.

### **3) EXPAND RECRUITING EFFORTS TO NONTRADITIONAL POPULATIONS**

As health care moves more into the community, it becomes even more critical to have health care workers that reflect the community they serve. Add this to the already described challenges of a low unemployment rate and aging population, and the argument to explore nontraditional recruiting sources is even stronger.

One employer discussed how there was a percentage of local high school graduates who do not go on to postsecondary education. The students going on to college interested him, but he is hoping to target students who currently are not on that track and try to convert them to some level of postsecondary education or training in high-demand middle skill occupations within health care.

JFF recommends that employer champions who support this approach advocate it to their peers and extend it to other target populations that are untapped/underutilized; those with mental/physical disabilities, new Americans, veterans, and military retirees (who typically retire young and begin second careers). Also, middle skill health care jobs are predominately filled by female workers. More could be done to target recruiting efforts to male workers.

#### **Assets**

New Hampshire possesses strong community-based organizations and trainers that know the sector as well as a variety of populations that fall outside traditional recruitment groups such as opportunity youth, career and technical education high school students, the growing new American population, the disability community, veterans, and military retirees. These organizations include New Hampshire Job Corp, Easter Seals, Southern New Hampshire Services, and Project Lead the Way.

Littleton high school was noted in interviews as a model with its health track in freshman year that exposes students to health care careers. Their Hugh J. Gallen Career & Technical Center’s 2016-2017 Career Pathways and Program of Studies includes a wealth of information on health

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<sup>29</sup> National Fund for Workforce Solutions. August 2011. “Employer-paid tuition advancement for low-income workers”. Available at: [http://skill-works.org/documents/NFWS-CHBTuitionAdvancementbestpractices\\_080911.pdf](http://skill-works.org/documents/NFWS-CHBTuitionAdvancementbestpractices_080911.pdf).

care and other sector pathways. The high school partners with Littleton Hospital on its certified medical assistant program, with most graduates moving on to employment at the hospital.

## **Strategic Recommendations**

***Better prepare youth for opportunities in all health care subsectors.*** Project Lead the Way's Biomedical Science curriculum is only being offered in one high school in the state. Increasing the number of high schools in which it is offered is another promising strategy for enhancing the health care pathway. Career and technical education interviewees still feel as though they are fighting for a seat at the table and expressed an interest in expanding the guided pathways at community colleges to connect with CTE programs. Salem High School's CTE Center has a strong LNA program, but they struggle to offer enough clinical rotations to provide students with work experience.

***Explore a partnership with Easter Seals.*** Easter Seals is a health care employer themselves so they know the business, is a strong workforce provider, has major statewide presence (over 20 offices statewide), and works with persons with disabilities, an underutilized labor pool.

***Deepen partnerships with Adult Basic Education.*** The ABE schools enroll about 7,000 people per year and approximately 15 percent of these individuals are unemployed and more are underemployed. There is an existing partnership between the workforce system and these schools that can be leveraged and deepened. ABE is a primary provider of related instruction for Registered Apprenticeships in New Hampshire. It is worth exploring whether additional collaboration and targeted industry involvement and recruitment efforts with the school would help address some of the industry's hiring needs. The fact that students are enrolled in these schools suggest these individuals may be interested in career advancement and have some of the employability skills in which employers are interested. The America's Job Centers/New Hampshire Works Centers are well positioned to help with assessment and job placement efforts.

***Cities and towns should consider partnering with refugee resettlement agencies.*** The southern part of the state (Manchester) has had success with training and employing members of the growing refugee population. The northern part of the country has not been able to take advantage of this recruiting source and should look in to partnering with either of the New Hampshire resettlement agencies: Ascentria Care Alliance and the International Institute of New Hampshire. There are a variety of resources and services available through the New Hampshire

Office of Minority Health and Refugee Affairs' Refugee Program to help the refugee population successfully integrate into the community.<sup>30</sup>

#### **4) CONNECT TO ECONOMIC AND COMMUNITY DEVELOPMENT EFFORTS**

Health care stakeholder interviews revealed that the sector's workforce challenges are also larger, economic and community development challenges for the state. An analysis of economic diversification efforts across the country found that increased diversification makes for a much more stable economy that can weather the ups and downs of the market. Diversification requires significant regional planning and collaboration as well as investments in infrastructure, education, and training. Another key finding was the importance of developing and marketing amenities and vibrant downtown areas that "may improve the quality of life for local residents and serve as a magnet for potential new residents".<sup>31</sup>

#### **Assets**

Health care stakeholders agree that the ultimate challenge for all New Hampshire employers is the lack of people to train, educate, and employ. This report has cited the state's low unemployment rate and the aging workforce as contributing factors. Stakeholders also feel that New Hampshire has a public relations problem, in that people believe they need to leave New Hampshire for a good job and life. A New Hampshire health care partnership as well as other New Hampshire sector partnerships are strong assets and they have the opportunity to market the career opportunities in the state to existing and potential residents. The state needs to develop a strong, unified answer to the question, why live and work in New Hampshire?

The New Hampshire Department of Resources and Economic Development (DRED) is aware of this challenge and is involved in multiple efforts to address it. In addition to being key partners in the New Hampshire Sector Partnership Initiative, DRED is currently working on a statewide Talent Attraction Marketing Campaign for technology and manufacturing.

Key assets and partners in economic and community development are the nine New Hampshire regional planning commissions as well as the statewide Association of Regional Planning Commissions (NHARPC). The industry associations could be an asset here as well in representing their members in these various efforts and partnerships.

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<sup>30</sup> New Hampshire Refugee Population. Nd. New Hampshire Department of Health and Human Services, Office of Minority Health and Refugee Affairs. Accessible at: <http://www.dhhs.nh.gov/omh/refugee/>.

<sup>31</sup> Appalachian Regional Commission. February 2014. "Economic Diversity in Appalachia: Case Studies in Economic Diversification". Available at: [http://www.arc.gov/assets/research\\_reports/EconomicDiversityinAppalachiaCompilationofAllReports.pdf](http://www.arc.gov/assets/research_reports/EconomicDiversityinAppalachiaCompilationofAllReports.pdf).

## Strategic Recommendations

**Connect to existing marketing efforts and launch additional campaigns.** The health care partnership should advocate to be included in DRED's marketing campaign as well as other statewide efforts to attract talent to New Hampshire and to retain existing workers. The partnership should also develop its own efforts that could include profiles and videos of middle skill workers in all of the subsectors, in particular long-term care which needs to increase awareness of this environment and type of health care service. Developing a marketing campaign and materials featuring the extended career pathways will go a long way to promoting health care pathways and opportunities in New Hampshire along the cradle-to-grey pipeline. Personal stories from diverse workers are always impactful when trying to recruit from a variety of target groups. Dissemination should be a multi-pronged approach spanning high schools, CTE centers, guidance counselors, New Hampshire Works staff, community colleges, veterans services representatives, etc. and utilizing a variety of media and social media outlets.

**Connect with community development and regional planning efforts.** A North Country hospital reported that the shortage or lack of affordable, quality housing, certain amenities, and other sector employers in the area is a huge barrier to recruiting and retaining talent. Combining workforce challenges with regional planning efforts that are also taking in to account housing, transportation, and other needs can put NH in a better position to leverage a broader array of local resources as well as federal grant programs, tax incentives, and special financing.

The U.S. Department of Housing and Urban Development (HUD) offers a variety of programs that support economic development projects of which job training and workforce related strategies are key components. These include Community Development Block Grants (CDBG), the Rural Innovation Fund (RIF), the Choice Neighborhoods Program, the Promise Zone Initiative, and the Sustainable Communities Initiative.<sup>32</sup>

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<sup>32</sup> HUD Policy Areas: Community and Economic Development. Nd. Accessible at: <https://www.hudexchange.info/programs/policy-areas/#community-and-economic-development>.

## 5) ADVOCATE FOR STATE LEGISLATIVE AND ADMINISTRATIVE POLICIES TO SUPPORT HEALTH CARE WORKFORCE

Health care is a complex sector that is considerably impacted by both federal and state policy. Employers referenced the challenging regulatory environment in which they have to operate. Sector partnerships are uniquely positioned to focus on reforming and improving policies and systems that will have long lasting impact in addition to more immediate training and education outcomes. In addition, they can influence the direction of public resources to workforce strategies that work such as registered apprenticeships and career pathways. Since by definition they include a wide range of stakeholders within a sector, any recommendations they make come from practice and carry a certain weight.<sup>33</sup>

### Assets

As previously mentioned, the health care sector has strong industry associations that have policy priorities based on their membership. Unifying the policy campaigns into one health care platform will serve to strengthen and advance all associations' work and benefit the sector as a whole.

In recognition of the current and impending shortages and workforce needs in the health care sector, former Governor Margaret Hassan issued an executive order creating the Commission on Health Care and Community Support Workforce in April 2016. Committee membership represented diverse health care stakeholders and opportunities for public testimony were offered across the state. The result was a report issued in December 2016 with findings and recommendations in five areas: licensure and certification; direct support professionals; data collection and analytics; education and training; and financial supports.<sup>34</sup>

### Strategic Recommendations

***As a partnership, review the recommendations in the commission's report and prioritize, identifying which to advocate for/support.*** A goal of sector partnership is to eliminate duplication in favor of integrating and leveraging efforts to work more effectively and efficiently together. In this spirit, we recommend not doing an additional review of state legislative and administrative policies. Rather, we recommend the partnership utilize the recent report

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<sup>33</sup> Lisa Soricone, Jobs for the Future. November 2015. "Systems Change in the National Fund for Workforce Solutions". Available at: <http://www.jff.org/sites/default/files/publications/materials/Systems-Change-in-the-National-Fund-120415.pdf>.

<sup>34</sup> The Governor's Commission on Health Care and Community Support Workforce, December 2016. "Report to Governor Hassan: Recommendations on Health Care and Community Support Workforce". Available at: <http://www.dhhs.nh.gov/ombp/caremgmt/health-care/documents/hc-20161216-recommendations.pdf>.

(executive summary in Appendix 3) from the governor's commission, which completed a rigorous review of policies and made subsequent recommendations which strongly resonate with the findings in this report. The partnership should assess if there are any additional recommendations that are not included in the report, and prioritize the recommendations that the partnership recommends the new governor address immediately.

Below are policy barriers that were identified through the stakeholder interviews and are also reflected in the commission's findings.

Health care employers are competing with neighboring states like Vermont and Massachusetts that do not have as many requirements and regulations as New Hampshire. And, in some cases, such as medical assistants, there are added requirements and regulations that exist in New Hampshire, but not in neighboring states like Vermont and Massachusetts. Many employers reference a recent New Hampshire law RSA 328-I that requires "health care workers with access to controlled substances and with access to or contact with patients in a health care facility or in a medical establishment" to be listed on a medical technician registry.<sup>35</sup> Employers say that the registry, which requires staff to complete fingerprint background check and pay a fee, is a challenge.

The lack of a clear definition of a medical assistant is also troubling as there are differences in qualifications and job duties depending on whether someone is a licensed nursing assistant or an uncertified medical assistant. Employers noted that medical assistants often wear multiple hats, especially in leaner-staffed organizations, and are being called upon to do a variety of tasks that may not be reflected in their job description.

Many health care employers cited licensure as a recruitment barrier. Health care contains a variety of credentials and licensing boards and employers reported that there are sometimes delays in processing certifications. A New Hampshire health care partnership should meet with all the relevant licensing boards to discuss recruitment challenges related to licensure and see what solutions can be negotiated, such as options for streamlining licensure for targeted occupations.

As previously mentioned, the cost of postsecondary education is a barrier. The New Hampshire DHHS loan repayment program is an asset, but has limited resources and scope. We recommend the partnership advocate for allocating more resources to this and any other loan repayment programs as well as expanding the scope to include short-term certificates and

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<sup>35</sup> New Hampshire Office of Professional Licensure and Certification. N.d. "Board of Registration for Medical Technicians". Available at: <http://www.oplc.nh.gov/medical-technicians/index.htm>.

degree programs in critical occupations at all levels. Addressing the cost of career advancement could make a significant impact in attracting jobseekers to the field, but there is a need to further invest in and restructure these resources to employer need and then increase awareness of these resources both in and outside of the state.

## **ESTABLISHING A SECTOR PARTNERSHIP**

The disconnected nature of New Hampshire's health care sector greatly contributes to the challenge of meeting the looming increasing health care needs of its residents. What is required is a paradigm shift from the traditional, competitive mindset among employers to a more collaborative, sector approach to growing, recruiting, and retaining talent. Individual employers need to meet their staffing needs, yes, but there also needs to be a refocusing on the greater good of the sector and community. For instance, investing in workers is a win even if they move on to peer employers, as long as the New Hampshire health care sector retains them. Employers acknowledged that this is a tough transition to make, but crucial when thinking of their legacy for New Hampshire health care. It is crucial also for education and workforce partners as they try to develop both credit and noncredit programs. Educators and trainers expressed the need for honest communication with employers on what their collective needs are so that they can design classes and cohorts accordingly and produce graduates that can obtain employment.

New Hampshire has a robust health care sector with committed employers as well as workforce and education organizations who want to work together on solutions. The spirit of collaboration is evident, but needs to be brought to a statewide level and needs a catalyst. Within health care there are subsectors that have very respected and active associations such as the New Hampshire Hospital Association, the New Hampshire Nursing Association, the New Hampshire Health Care Association, and others. Increased collaboration among these key stakeholders increases their collective power and potential for impact both at the local and statewide levels. These associations admitted they all have parallel policy and advocacy initiatives and should be integrating efforts.

A statewide convener that focuses across the whole health care sector is critical in advancing and sustaining a New Hampshire health care partnership that can work on immediate and long-term outcomes and contribute to a thriving New Hampshire economy. This convener, or intermediary, will serve as a bridge, connecting employers with workforce and education partners that can meet their hiring needs. This type of work takes time, and sector partnerships are much more successful if they are supported by dedicated staff.

We recommend that the sector partnership be structured to facilitate widespread participation among stakeholders while ensuring deep engagement and time commitment from its members.

The sector partnership can clarify forms of engagement and expectations of members early to ensure effective participation. We recommend that:

- The sector partnership includes members that represent health care employers of all sizes and subsectors, secondary and postsecondary educational institutions, third-party training vendors, registered apprenticeship providers, the workforce system, state and local agencies including economic development agencies, community-based organizations, and policymakers.
- Business leaders co-chair the partnership to ensure that the efforts are industry-led and represent the three key types of health care employers: 1) ambulatory health care services; 2) hospitals; and 3) nursing and residential care facilities. The chairs recruit their peers to participate in the partnership; develop agendas and lead meetings; represent the partnership on the State Workforce Innovation Board (SWIB) and other statewide efforts; in collaboration with the intermediary, work with employers and other partners to develop short and long-term strategies based on industry input and the asset map; participate in workforce activities that stem from the partnership; and provide direction to the intermediary.
- An executive committee helps guide the sector partnership agenda and recruits partners to the effort. Roles on the committee are fulfilled by different stakeholder groups, for instance, two to four employers, one community college educator, one community-based organization, one career and technical education high school, and one workforce development partner. The executive committee convenes in between larger partnership meetings to provide input on agenda and work on projects.
- The New Hampshire Health Care Association (NHHCA) serves as intermediary to convene and staff the partnership and manage projects between meetings to ensure accountability and progress toward goals. This role includes a number of critical responsibilities, such as coordinating partnership meetings; recruiting champions in every region in concert with the co-chairs; engaging workforce system, education and training providers, community-based organizations, and other key stakeholders in partnership meetings; accessing diverse financial resources from public, private, and philanthropic sources to support workforce services; and facilitating solutions and action steps at partnership meetings to advance progress on strategy, based initially on strategies identified in the sector's asset map and report.
- In alignment with structures and processes established by the NH Sector Partnership Initiative and the NH State Workforce Investment Board to support collaboration and information sharing among all the state's sector partnerships, the partnership incorporates a relationship with the other sector partnerships in technology, hospitality, and manufacturing.

# APPENDIX

## APPENDIX 1. TOP HEALTH CARE SUBSECTOR DATA

In the section that follows, detailed data are provided for the ambulatory health care services, hospital, and nursing and residential care facilities subsectors.<sup>36</sup> As discussed in the main report, each subsector employs a significant number of registered nurses; however, there are some differences in the distribution of occupations within each subsector. For example, within ambulatory care and hospitals, there is a greater number of staff in nonpatient-care roles, including receptionists, medical secretaries, and medical/health services managers. On the other hand, medical technician occupations are most prominent within the hospital subsector. Despite these differences in occupational employment across the subsectors, a set of common skills emerged across the sector. Communication skills (and/or English) were the top requested baseline skills across each subsector, according to job ad data from Burning Glass.

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<sup>36</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

**Technologies.** These data also highlighted the need for Microsoft Office skills across each subsector.

**Table 1. Top Ambulatory Care Occupations, Based Upon Employment (NAICS 621)<sup>37</sup>**

SOC	Description	Employed in Industry (2015)	% of Total Jobs in Industry (2016)	Median Hourly Earnings
29-1141	Registered Nurses	2,248	6.1%	\$30.63
43-4171	Receptionists and Information Clerks	2,059	5.5%	\$13.70
31-9092	Medical Assistants	1,737	4.7%	\$16.28
43-6013	Medical Secretaries	1,673	4.5%	\$16.43
39-9021	Personal Care Aides	1,638	4.4%	\$10.75
19-3031	Clinical, Counseling, and School Psychologists	1,474	4.0%	\$38.39
29-1069	Physicians and Surgeons, All Other	1,472	4.0%	\$99.17
31-9091	Dental Assistants	1,272	3.4%	\$21.45
31-1011	Home Health Aides	1,257	3.4%	\$11.78
29-2021	Dental Hygienists	1,149	3.1%	\$39.18

<sup>37</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

**Table 2. Ambulatory Care Job Ad Data<sup>38</sup>**

TOP TITLES	TOP SKILLS		
	Baseline Skills	Specialized Skills	Software Skills
<b>Physical Therapists</b>	Communication Skills	Patient Care	Microsoft Excel
<b>Registered Nurses</b>	Computer Skills	Cardiopulmonary Resuscitation (CPR)	Microsoft Word
<b>Nursing Assistants</b>	English	Critical Care	Pointclickcare
<b>Medical and Clinical Laboratory Technicians</b>	Planning	Nurse Management	ICD-9-CM Coding
<b>Nurse Practitioners</b>	Team Work/ Collaboration	Post Anesthesia Care Unit (PACU)	PrognosIS
<b>Critical Care Nurses</b>	Supervisory Skills	Treatment Planning	EPIC software
<b>Medical and Health Services Managers</b>	Customer Service	Advanced Cardiac Life Support (ACLS)	Meditech
<b>Speech-Language Pathologists</b>	Building Effective Relationships	Neonatal Intensive Care Unit (NICU)	Geographic Information System (GIS)

<sup>38</sup> Burning Glass Technologies. Labor/Insight. Parameters: data is for the state of New Hampshire from September 2015 to August 2016 for the ambulatory care subsector. Skills and titles are based upon 5,126 total job postings.

**Table 3. Nursing and Residential Care Occupations (NAICS 623)<sup>39</sup>**

<b>SOC</b>	<b>Description</b>	<b>Employed in Industry (2015)</b>	<b>% of Total Jobs in Industry (2016)</b>	<b>Median Hourly Earnings</b>
31-1014	Nursing Assistants	4,836	31.9%	\$13.87
39-9021	Personal Care Aides	1,455	9.7%	\$11.01
29-1141	Registered Nurses	888	5.9%	\$31.35
29-2061	Licensed Practical and Licensed Vocational Nurses	863	5.7%	\$22.64
37-2012	Maids and Housekeeping Cleaners	601	4.0%	\$10.73
31-1011	Home Health Aides	482	3.3%	\$12.35
35-3041	Food Servers, Non-restaurant	405	2.7%	\$10.12
35-2012	Cooks, Institution and Cafeteria	377	2.5%	\$14.17
21-1093	Social and Human Service Assistants	309	2.0%	\$13.85
39-9032	Recreation Workers	270	1.8%	\$12.53

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<sup>39</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

**Table 4. Nursing and Residential Care Job Ad Data<sup>40</sup>**

TOP TITLES	TOP SKILLS		
	Baseline	Specialized	Software and Programming
Registered Nurses	English	Patient Care	Pointclickcare
Licensed Practical and Licensed Vocational Nurses	Communication Skills	Treatment Planning	Microsoft Office
Nursing Assistants	Computer Skills	Cardiopulmonary Resuscitation (CPR)	Microsoft Windows
Medical and Health Services Managers	Team Work/ Collaboration	Rehabilitation	Yardi Software <sup>41</sup>
Physical Therapists	Quality Assurance and Control	Patient/Family Education and Instruction	YouTube
Speech-Language Pathologists	Planning	Supervisory Skills	
Food Servers, Non-restaurant	Organizational Skills	Instruction	CRM
Physical Therapist Assistants	Creativity	Patient Direction	ADP Payroll

<sup>40</sup> Burning Glass Technologies. Labor/Insight. Parameters: data is for the state of New Hampshire from September 2015 to August 2016 for the nursing and residential care subsector. Skills and titles are based upon 2,121 total job postings.

<sup>41</sup> Yardi is a property and asset management software.

**Table 5. Hospital Occupations (NAICS 622)<sup>42</sup>**

<b>SOC</b>	<b>Description</b>	<b>Employed in Industry (2015)</b>	<b>% of Total Jobs in Industry (2015)</b>
29-1141	Registered Nurses	8,406	29.8%
31-1014	Nursing Assistants	2,493	8.8%
11-9111	Medical and Health Services Managers	647	2.3%
29-1069	Physicians and Surgeons, All Other	616	2.2%
37-2012	Maids and Housekeeping Cleaners	614	2.2%
43-6013	Medical Secretaries	597	2.1%
43-4111	Interviewers, Except Eligibility and Loan	535	1.9%
29-1123	Physical Therapists	499	1.8%
29-2034	Radiologic Technologists	458	1.6%
29-2011	Medical and Clinical Laboratory Technologists	431	1.5%

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<sup>42</sup> Emsi Analyst. 2016.4 data extracted by S. Lamback.

**Table 6. Hospital Job Ad Data<sup>43</sup>**

TOP TITLES	TOP SKILLS		
	Baseline	Specialized	Software and Programming
<b>Registered Nurses</b>	Communication Skills	Patient Care	Microsoft Office
<b>Medical and Health Services Managers</b>	Team Work/ Collaboration	Scheduling	ICD-9-CM Coding
<b>Medical Assistants</b>	Planning	Customer Service	Microsoft Visio
<b>Patient Representatives</b>	Computer Skills	Patient Safety	Microsoft SharePoint
<b>Nursing Assistants</b>	Organizational Skills	Treatment Planning	Microsoft Project
<b>Physical Therapists</b>	Writing	Patient/Family Education and Instruction	HCPCS Coding
<b>Critical Care Nurses</b>	Quality Assurance and Control	Cardiopulmonary Resuscitation (CPR)	Meditech
<b>Licensed Practical and Licensed Vocational Nurses</b>	Problem Solving	Rehabilitation	Crystal Reports

<sup>43</sup> Burning Glass Technologies. Labor/Insight. Parameters: data is for the state of New Hampshire from September 2015 to August 2016 for the hospital subsector. Skills and titles are based upon 4,663 total job postings.

## APPENDIX 2: SAMPLE CAREER PATHWAYS

### Pathway 1: Dartmouth-Hitchcock Registered Apprenticeship Programs

To meet their workforce needs, Dartmouth-Hitchcock developed apprenticeship programs through their Workforce Readiness Institute. The Institute now offers registered apprenticeship in a variety of occupations including medical assistant, pharmacy technician, medical coder, patient registration representative, and phlebotomist.<sup>44</sup>



### Pathway 2: Health Science Career Cluster

This template, based on the National Career Clusters framework, was created to help students begin to understand what classes will help them become college- and career-ready in health sciences. The specifics will vary in high schools across the state to reflect the different programs and graduation requirements of each school. While not designed as a career pathway, it outlines a four-year high school plan for the health science career cluster in alignment with postsecondary educational opportunities, Registered Apprenticeships, other industry-recognized credentialing, and broader career options.

See following pages.

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<sup>44</sup> Dartmouth-Hitchcock. Nd. "Workforce Development Programs." Available at: <http://careers.dartmouth-hitchcock.org/workforce-development/programs.html>.

Planning, managing, and providing therapeutic services, diagnostic services, health informatics, support services, and biotechnology research and development.

CR	Subject	9 <sup>th</sup> Grade		10 <sup>th</sup> Grade		11 <sup>th</sup> Grade		12 <sup>th</sup> Grade	
4.0	English	<input type="checkbox"/> English I	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<input type="checkbox"/> English 2	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<input type="checkbox"/> English 3 <input type="checkbox"/> English Electives	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<input type="checkbox"/> English 3 <input type="checkbox"/> English 4 <input type="checkbox"/> English Electives	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4
2.5	Social Studies	<input type="checkbox"/> Civics	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<input type="checkbox"/> World History Survey	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<input type="checkbox"/> US History	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<input type="checkbox"/> Economics	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4
3.0	Math	<input type="checkbox"/> Math I <input type="checkbox"/> Algebra Skills <input type="checkbox"/> Algebra I <input type="checkbox"/> Geometry	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<input type="checkbox"/> Math 2 <input type="checkbox"/> Geometry Skills <input type="checkbox"/> Geometry <input type="checkbox"/> ALG 2/Trigonometry	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<input type="checkbox"/> Math 3 <input type="checkbox"/> Algebra Topics <input type="checkbox"/> ALG 2/Trigonometry <input type="checkbox"/> Pre-Calculus	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<b>Additional Math is Highly Recommended for Competitive Colleges &amp; Career Fields</b> <i>(See College Planning)</i>	
2.0	Science	<input type="checkbox"/> Physical Science <input type="checkbox"/> Earth Science <input type="checkbox"/> Space Science	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<input type="checkbox"/> Biology	<input type="checkbox"/> L1 <input type="checkbox"/> L2 <input type="checkbox"/> L3 <input type="checkbox"/> L4	<b>Additional Science is Highly Recommended for Competitive Colleges &amp; Career Fields</b> <i>(See College Planning)</i>		<b>Additional Science is Highly Recommended for Competitive Colleges &amp; Career Fields</b> <i>(See College Planning)</i>	
1.0	Physical Education	<input type="checkbox"/> Physical Education <input type="checkbox"/> Walking for Fitness		<input type="checkbox"/> Elective Physical Education <input type="checkbox"/> Team Sports					
0.5	Health Education	<input type="checkbox"/> <b>Health Education is taken in the freshman year.</b>							
0.5	Arts Education	<input type="checkbox"/> <b>Art/Music/Theater is recommended for the freshman year.</b> This requirement can also be met with the following interdisciplinary courses: Theater, Sewing, Computer Animation, Video Production, and Web Design.							
0.5	Information Communications and Technology Education	<input type="checkbox"/> <b>ICT is recommended for the freshman year.</b> This requirement can also be met with the following interdisciplinary courses:							
		<input type="checkbox"/> Computer Graphics I <input type="checkbox"/> Programming in C <input type="checkbox"/> Principles of Engineering		<input type="checkbox"/> Drafting <input type="checkbox"/> Engineering Drawing <input type="checkbox"/> Intro to Video Production		<input type="checkbox"/> Advanced Video Production <input type="checkbox"/> Computer Animation <input type="checkbox"/> Web Design			
6.0+	Career Cluster Elective Courses	<b>Career Electives</b>				<b>Career &amp; Technical Education at MST</b>			
		<input type="checkbox"/> Career & Study Skills <input type="checkbox"/> Career Exploration <input type="checkbox"/> First Aid <input type="checkbox"/> Infant & Child Development <input type="checkbox"/> Chemistry <input type="checkbox"/> Physics		<input type="checkbox"/> Advanced Biology <input type="checkbox"/> Anatomy & Physiology <input type="checkbox"/> Human Anatomy <input type="checkbox"/> Biotechnology & Genetics <input type="checkbox"/> Sociology <input type="checkbox"/> Law & Ethics		<b>DON'T MISS OUT!</b> MST has a very strict application process. For more information: <a href="http://mst.mansd.org/about-mst/application">http://mst.mansd.org/about-mst/application</a>			
		<input type="checkbox"/> Health Science & Technology I		<input type="checkbox"/> Health Science & Technology II					
World Languages	<b>Although world languages are NOT required for graduation, they are highly recommended for students who will attend college. The following languages are offered:</b>								
	<input type="checkbox"/> French	<input type="checkbox"/> German	<input type="checkbox"/> Latin	<input type="checkbox"/> Spanish	<input type="checkbox"/> American Sign Language (Memorial).				
Additional Learning Opportunities	<input type="checkbox"/> 21 <sup>st</sup> Century Program <input type="checkbox"/> Alternative Learning for Freshmen <input type="checkbox"/> Catholic Medical Center Partnership <input type="checkbox"/> Community of Caring, Inc. <input type="checkbox"/> Community Service <input type="checkbox"/> Driver Education		<input type="checkbox"/> Education Talent Search <input type="checkbox"/> Extended Learning Opportunity <input type="checkbox"/> FIRST Robotics <input type="checkbox"/> Manchester-Neustadt Student Exchange <input type="checkbox"/> My Turn Career Program <input type="checkbox"/> NH-JAG			<input type="checkbox"/> Peer Tutorial program <input type="checkbox"/> Running Start <input type="checkbox"/> SNHU in the High School <input type="checkbox"/> Student Assistance <input type="checkbox"/> Upward Bound			

**Sample Requirements for College Planning**

Academic Area	Technical/Community Colleges	Selective Colleges	More Selective Colleges	Highly Competitive Colleges
	(L1)-Higher for some programs	(L2) and (L3)	Primarily (L3)	(L3), (L4) or AP
English	4 credits	4 credits	4 credits	4-5 credits
Mathematics	3 credits: including Algebra	3 credits: Algebra 1, Geometry, and Algebra 2 & Trigonometry (more in certain programs)	4 credits: Algebra 1, Geometry, and Algebra 2 & Trigonometry (more in certain programs)	4-5 credits: Algebra 1, Geometry, Algebra 2 & Trigonometry, and pre-Calculus (more in certain programs)
Science	2-3 credits: including Physical/Earth/Space/Science, Biology 1	3-4 credits: including Physical/Earth/Space/Science, Biology 1, Chemistry	4 credits: including Physical/Earth/Space/Science, Biology 1, Chemistry, Physics and/or Anatomy /Physiology	4 or 5 credits: including Physical/Earth/Space/Science, Biology 1, Chemistry, Physics and/or Anatomy /Physiology
Social Studies	American Civics, Economics, World History, US History, Electives	American Civics, Economics, World History, US History, Electives	American Civics, Economics, World History, US History, Electives	American Civics, Economics, World History, US History, Electives
World Languages	Optional	2 years of the same language	3 years of the same language	4-5 of the same language
Fine Arts		4-5 credits: Art/Music majors may need a portfolio and/or an audition	4-5 credits: Art/Music majors may need a portfolio and/or an audition	4-5 credits: Art/Music majors may need a portfolio and/or an audition

## Occupations by Career Cluster Pathways

<p><b>Biotechnology Research &amp; Development</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Biologists</li> <li><input type="checkbox"/> Biomedical Engineers</li> <li><input type="checkbox"/> Clinical Data Managers</li> <li><input type="checkbox"/> Clinical Research Coordinators</li> <li><input type="checkbox"/> Health Specialties Teachers, Postsecondary</li> <li><input type="checkbox"/> Mathematical Technicians</li> <li><input type="checkbox"/> Medical Equipment Preparers</li> <li><input type="checkbox"/> Medical Scientists, Except Epidemiologists</li> <li><input type="checkbox"/> Natural Sciences Managers</li> <li><input type="checkbox"/> Pharmacists</li> </ul> <p><b>Diagnostic Services</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ambulance Drivers and Attendants</li> <li><input type="checkbox"/> Athletic Trainers</li> <li><input type="checkbox"/> Cardiovascular Technologists/Technicians</li> <li><input type="checkbox"/> Diagnostic Medical Sonographers</li> <li><input type="checkbox"/> EMTs/ Paramedics</li> <li><input type="checkbox"/> Health Specialties Teachers</li> <li><input type="checkbox"/> Health Technologists and Technicians</li> <li><input type="checkbox"/> Medical and Clinical Laboratory Technologists/Technicians</li> <li><input type="checkbox"/> Medical and Health Services Managers</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Medical Assistants</li> <li><input type="checkbox"/> Nuclear Medicine Technologists/Technicians</li> <li><input type="checkbox"/> Ophthalmic Medical Technologists/Technicians</li> <li><input type="checkbox"/> Physician Assistants</li> <li><input type="checkbox"/> Radiation Therapists</li> <li><input type="checkbox"/> Radiologists/ Technologists/Technicians</li> <li><input type="checkbox"/> Respiratory Therapy Technicians</li> <li><input type="checkbox"/> Surgical Technologists</li> </ul> <p><b>Health Informatics</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Informatics Nurse Specialist</li> <li><input type="checkbox"/> Medical and Health Services Manager</li> <li><input type="checkbox"/> Medical Assistant</li> <li><input type="checkbox"/> Medical Records/Health Information Technician</li> <li><input type="checkbox"/> Medical Transcriptionist</li> </ul> <p><b>Support Services</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ambulance Driver/Attendant</li> <li><input type="checkbox"/> Athletic Trainer</li> <li><input type="checkbox"/> Medical Equipment Preparer</li> <li><input type="checkbox"/> Medical/Clinical Laboratory Technician</li> <li><input type="checkbox"/> Medical/Clinical Laboratory Technologist</li> <li><input type="checkbox"/> Occupational Health &amp; Safety Specialist</li> <li><input type="checkbox"/> Speech-Language Pathologist</li> </ul>	<p><b>Therapeutic Services</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acupuncturist</li> <li><input type="checkbox"/> Anesthesiologist</li> <li><input type="checkbox"/> Audiologist</li> <li><input type="checkbox"/> Chiropractor</li> <li><input type="checkbox"/> Coroner</li> <li><input type="checkbox"/> Dental Assistant/Hygenist</li> <li><input type="checkbox"/> Dental Laboratory Technician</li> <li><input type="checkbox"/> Dentist</li> <li><input type="checkbox"/> Dietetic Technician</li> <li><input type="checkbox"/> Dietitian/Nutritionist</li> <li><input type="checkbox"/> Dispensing Optician</li> <li><input type="checkbox"/> Embalmer</li> <li><input type="checkbox"/> Emergency Medical Technician/Paramedic</li> <li><input type="checkbox"/> Family/General Practitioner</li> <li><input type="checkbox"/> General Internist</li> <li><input type="checkbox"/> Genetic Counselor</li> <li><input type="checkbox"/> Home Health Aide</li> <li><input type="checkbox"/> Licensed Practical Nurse</li> <li><input type="checkbox"/> Massage Therapist</li> <li><input type="checkbox"/> Medical Assistant</li> <li><input type="checkbox"/> Naturopathic Physician</li> <li><input type="checkbox"/> Nuclear Medicine Physician</li> <li><input type="checkbox"/> Nurse Aide/Orderly</li> <li><input type="checkbox"/> Nurse Midwife</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Nurse Practitioner</li> <li><input type="checkbox"/> Obstetrician and Gynecologist</li> <li><input type="checkbox"/> Occupational Therapist/Assistant/Aide</li> <li><input type="checkbox"/> Optometrist</li> <li><input type="checkbox"/> Oral Surgeon</li> <li><input type="checkbox"/> Orthodontist</li> <li><input type="checkbox"/> Orthotist/Prosthetist</li> <li><input type="checkbox"/> Pathologist</li> <li><input type="checkbox"/> Pediatrician</li> <li><input type="checkbox"/> Pharmacist/Technician/Aide</li> <li><input type="checkbox"/> Physical Therapist/Assistant/Aide</li> <li><input type="checkbox"/> Physician Assistant</li> <li><input type="checkbox"/> Podiatrist</li> <li><input type="checkbox"/> Prosthodontist</li> <li><input type="checkbox"/> Psychiatrist/Technician/Aide</li> <li><input type="checkbox"/> Radiation Therapist</li> <li><input type="checkbox"/> Recreational Therapist</li> <li><input type="checkbox"/> Registered Nurse</li> <li><input type="checkbox"/> Respiratory Therapist/Technician</li> <li><input type="checkbox"/> Speech-Language Pathologist</li> <li><input type="checkbox"/> Surgeon</li> <li><input type="checkbox"/> Surgical Technologist</li> <li><input type="checkbox"/> Veterinarian/Technologist/Technician</li> <li><input type="checkbox"/> Veterinary Assistant/Laboratory Animal Caretaker</li> </ul>
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## Occupations by Education

<p><b>High School Preferred</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ambulance Driver/Attendant</li> <li><input type="checkbox"/> Dental Laboratory Technician</li> <li><input type="checkbox"/> Home Health Aide</li> </ul> <p><b>High School Completed (GED)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dental Assistant</li> <li><input type="checkbox"/> Dietetic Technician</li> <li><input type="checkbox"/> Dispensing Optician</li> <li><input type="checkbox"/> Medical Equipment Preparer</li> <li><input type="checkbox"/> Occupational Therapy Aide</li> <li><input type="checkbox"/> Pharmacy Aide</li> <li><input type="checkbox"/> Pharmacy Technician</li> <li><input type="checkbox"/> Physical Therapist Aide</li> <li><input type="checkbox"/> Psychiatric Aide</li> <li><input type="checkbox"/> Veterinary Assistant/Laboratory Animal Caretaker</li> </ul> <p><b>Certificate or Associate Degree</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cardiovascular Technologist/Technician</li> <li><input type="checkbox"/> Clinical Nurse Specialist</li> <li><input type="checkbox"/> Dental Hygienist</li> <li><input type="checkbox"/> Diagnostic Medical Sonographer</li> <li><input type="checkbox"/> Embalmer</li> <li><input type="checkbox"/> Emergency Medical Technician/Paramedic</li> <li><input type="checkbox"/> Licensed Practical Nurse</li> <li><input type="checkbox"/> Massage Therapist Medical Assistant</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Medical Records/Health Information Technician</li> <li><input type="checkbox"/> Medical Transcriptionist</li> <li><input type="checkbox"/> Medical/Clinical Laboratory Technician</li> <li><input type="checkbox"/> Neurodiagnostic Technologist</li> <li><input type="checkbox"/> Nuclear Medicine Technologist</li> <li><input type="checkbox"/> Nurse Aide/Orderly</li> <li><input type="checkbox"/> Occupational Therapy Assistant</li> <li><input type="checkbox"/> Phlebotomist</li> <li><input type="checkbox"/> Physical Therapy Assistant</li> <li><input type="checkbox"/> Psychiatric Technician</li> <li><input type="checkbox"/> Radiation Therapist</li> <li><input type="checkbox"/> Radiologic Technician</li> <li><input type="checkbox"/> Radiologic Technologist</li> <li><input type="checkbox"/> Registered Nurse</li> <li><input type="checkbox"/> Respiratory Therapist</li> <li><input type="checkbox"/> Respiratory Therapy Technician</li> <li><input type="checkbox"/> Speech-Language Pathology Assistant</li> <li><input type="checkbox"/> Surgical Technologist</li> <li><input type="checkbox"/> Veterinary Technician/Technologist</li> </ul> <p><b>Bachelor's Degree</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Art Therapist</li> <li><input type="checkbox"/> Athletic Trainer</li> <li><input type="checkbox"/> Coroner</li> <li><input type="checkbox"/> Cytogenetic Technologist</li> <li><input type="checkbox"/> Dietitian/Nutritionist</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Exercise Physiologist</li> <li><input type="checkbox"/> Informatics Nurse Specialist</li> <li><input type="checkbox"/> Medical and Health Services Manager</li> <li><input type="checkbox"/> Medical/Clinical Laboratory Technologist</li> <li><input type="checkbox"/> Music Therapist</li> <li><input type="checkbox"/> Occupational Health and Safety Specialist</li> <li><input type="checkbox"/> Orthotist and Prosthetist</li> <li><input type="checkbox"/> Physician Assistant</li> <li><input type="checkbox"/> Recreational Therapist</li> </ul> <p><b>Professional or Graduate Degree</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acupuncturist</li> <li><input type="checkbox"/> Allergist/Immunologist</li> <li><input type="checkbox"/> Anesthesiologist</li> <li><input type="checkbox"/> Audiologist</li> <li><input type="checkbox"/> Chiropractor</li> <li><input type="checkbox"/> Dentist</li> <li><input type="checkbox"/> Dermatologist</li> <li><input type="checkbox"/> Family/General Practitioner</li> <li><input type="checkbox"/> General Internist</li> <li><input type="checkbox"/> Genetic Counselor</li> <li><input type="checkbox"/> Hospitalist</li> <li><input type="checkbox"/> Naturopathic Physician</li> <li><input type="checkbox"/> Neurologist</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Nuclear Medicine Physician</li> <li><input type="checkbox"/> Nurse Anesthetist</li> <li><input type="checkbox"/> Nurse Midwife</li> <li><input type="checkbox"/> Nurse Practitioner</li> <li><input type="checkbox"/> Obstetrician and Gynecologist</li> <li><input type="checkbox"/> Occupational Therapist</li> <li><input type="checkbox"/> Ophthalmologist</li> <li><input type="checkbox"/> Optometrist</li> <li><input type="checkbox"/> Oral Surgeon</li> <li><input type="checkbox"/> Orthodontist</li> <li><input type="checkbox"/> Pathologist</li> <li><input type="checkbox"/> Pediatrician</li> <li><input type="checkbox"/> Pharmacist</li> <li><input type="checkbox"/> Psychiatrist</li> <li><input type="checkbox"/> Physical Therapist</li> <li><input type="checkbox"/> Podiatrist</li> <li><input type="checkbox"/> Prosthodontist</li> <li><input type="checkbox"/> Psychiatrist</li> <li><input type="checkbox"/> Radiologist</li> <li><input type="checkbox"/> Speech-Language Pathologist</li> <li><input type="checkbox"/> Sports Medicine Physician</li> <li><input type="checkbox"/> Surgeon</li> <li><input type="checkbox"/> Urologist</li> <li><input type="checkbox"/> Veterinarian</li> </ul>
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## Military Occupations by Rank

For more military occupations: <http://www.myfuture.com/military/>

**Enlisted:** Enlisted members are employed in almost every type of military career, often in hands-on roles. They make up approximately 83 percent of the overall active-duty military workforce.

**Officers:** Officers are generally employed in management roles or highly specialized fields that require more training (e.g., doctors, lawyers and chaplains). Commissioned officers account for approximately 17 percent of all active-duty service members.

**CCSNH Certificates and Associate Degrees**

D=Diploma C=Certificate A=Associate	GBCC	LRCC	MCC	NCC	NHTI	RVCC	WMCC
Coaching				C			
Cyber Security & Health Care IT						A/C	C
Dental Assisting					C		
Dental Hygiene					A		
Diagnostic Medical Sonography					C		
Exercise Science			A				
Gerontology		C					
Health & Wellness Advocate							C
Health & Wellness Coach							C
Health Information			A			A	
Health Information Technology	A	A					
Health Science			A		A		A
Legal Nurse Consultant					C		
Licensed Nursing Assistant		C				C	
Massage / Holistic Massage	A/C			A/C		C	C
Medical Administrative Assistant	C	C	C			C	A
Medical Assistant			A/C			C	A/C
Medical Coding			C		C		C
Medical Laboratory Technician						A	
Nursing	A	A	A	A	A	A	A
Nursing - AP Program	A	A	A		A	A	
Occupational Therapy Assistant						A	
Orthopaedic Technology					A/C		
Paramedic Emergency Medicine					A		
Personal Training			C				
Phlebotomy			C			C	
Physical Therapist Assistant						A	
Polysomnographic Technologist						C	
Practical Nursing						D	
Radiation Therapy					A/C		
Radiologic Technology					A		
Respiratory Therapy						A	
Speech-Language Pathology				A			
Surgical Technology	A						
Veterinary Practice Management	C						
Veterinary Technology	A						

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**NH Bachelor Degrees**

	CSC	DAR	FPU	GSC	KSC	MCPHS	NEC	NHIA	PSU	RIV	SAC	SNHU	UNH	HAU
Applied Studies-Allied Health				*										
Athletic Training	*													
Behavioral Science				A										
Biology	*	*	*		*		*		*	*	*	*	*	*
Biochemistry		*							*		*	*	*	*
Biotechnology									*					
Chemistry		*			*				*		*	*	*	*
Communication Sciences & Disorders				A										
Forensic Science											*			
Genetics													*	
Healthcare Administration							*					*		
Healthcare Management				*										
Health Education/Promotion	*								*					
Health Information Management												*		
Health Promotion												*		
Health Promotion & Fitness					*									
Health Science				*		*						*	*	
Health & Wellness				*										
Human Development										*				
Nursing	*			*					*	*	*			
Nutrition					*								*	
Physical Education									*					
Substance Abuse/Addiction					*									
Kinesiology							*						*	
Medical Laboratory Science													*	
Microbiology													*	
Neuroscience & Behavior	*												*	
Neuroscience Physics		*												
Occupational Safety					*									
Occupational Therapy													*	
Pharmacy	*													
Physician Assistant														
Psychology	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Public Health	*									*				
Exercise/Sports Physiology	*								*				*	
Sociology	*									*	*			
Sports Medicine/Athletic Training	*				*								*	

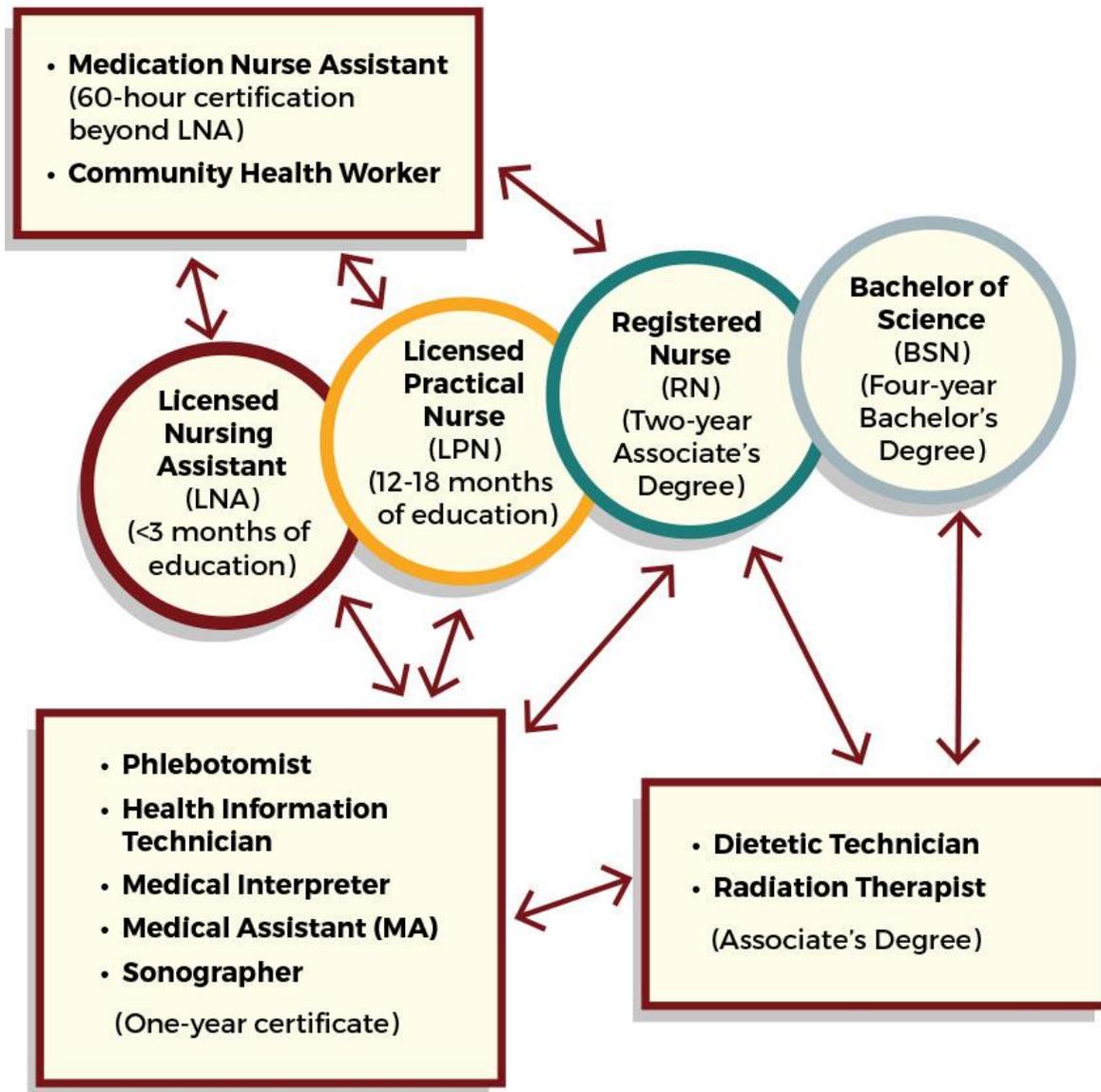
CSC=Colby-Sawyer College  
 DAR=Dartmouth College  
 FPU=Franklin Pierce University  
 GSC=Granite State College  
 KSC=Keene State College  
 MCPHS=MA College of Pharmacy & Health Science  
 NEC=New England College

NHIA=NH Institute of Art  
 PSU=Plymouth State University  
 RIV=Rivier University  
 SAC=St. Anselm College  
 SNHU=Southern NH University  
 UNH=University of NH  
 HAU=Hellenic American University

Rev. 10/15/12

### Pathway 3: Multiple Paths to Multi-Skill Training and Career Advancement

This pathway was developed as part of a report by the Institute on Assets and Social Policy in partnership with the New Hampshire Office of Minority health and Refugee Affairs to demonstrate a health care pathway that has multiple on and off ramps to advancement.<sup>45</sup>



<sup>45</sup> Institute on Assets and Social Policy. 2014. "Strengthening New Hampshire's Health Care Workforce: Strategies for Employers and Workforce Development Leaders." Available at: <https://iasp.brandeis.edu/pdfs/2014/Workforce.pdf>.

#### **Pathway 4: ApprenticeshipUSA Registered Apprenticeship in Health Science**

Registered apprenticeships are work-based learning programs that offer workers an opportunity to be paid while receiving on-the-job training. ApprenticeshipUSA is the federal apprenticeship system in the United States. Under this system, New Hampshire has registered apprenticeship in a variety of health care pathways including therapeutic services, diagnostic services, health informatics, support services, and biotechnology research and development.

*See following page.*

## REGISTERED APPRENTICESHIP

# OCCUPATIONS

- Cooks, Institution & Cafeteria
- Dental Assistants
- Dental Laboratory Technicians
- Emergency Management Directors
- Emergency Medical Technicians & Paramedics
- Home Health Aides
- Licensed Practical & Licensed Vocational Nurses
- Medical & Clinical Laboratory Technicians
- Medical & Health Services Managers
- Medical Appliance Technicians
- Medical Assistants
- Medical Equipment Preparers
- Medical Records & Health Information Technicians
- Nursing Assistants
- Ophthalmic Laboratory Technicians
- Opticians, Dispensing
- Orthotists & Prosthetists
- Pharmacy Technicians
- Phlebotomists
- Physical Therapy Aide
- Radiologic Technologists
- Residential Advisors
- Surgical Technologists
- Veterinary Assistants & Laboratory Animal Caretakers

Browse for more occupations at:  
<http://www.mynextmove.org/find/browse?c=62>

## EMPLOYERS

- Armed services
- Colleges or universities
- Community health clinics
- Correctional facilities
- Federal, state, & local health departments
- Fitness centers
- Health clinics
- Health networks
- Home healthcare agencies
- Hospitals
- Mental health institutions
- National Health Service
- Pharmaceutical companies
- Physicians' offices
- Sports medicine facilities
- Rehabilitation centers
- Research laboratories
- Residential and nursing homes
- Sports facilities
- Veterinary clinics
- Vision care centers

Retrieved from <http://www2.isu.edu/career/majors/html/medicalfields.html> and <http://www2.isu.edu/career/majors/html/exercisescience.html>

## NH CAREER & TECHNICAL EDUCATION

### Health & Wellness, General

- River Valley Technical Center, Springfield, VT

### Health Professions & Related Services

- Berlin Regional Career & Technical Center
- River Bend Career & Technical Center, Bradford, VT
- Concord Regional Technical Center, Concord
- Mt. Washington Valley Career Tech Ctr., Conway
- Pinkerton Academy Center for CTE, Derry
- Dover Career Technical Center, Dover
- Seacoast School of Technology, Exeter
- Wilbur H. Palmer Career & Tech Ed Ctr., Hudson
- The Cheshire Career Center, Keene

- J O Huot Technical Center, Laconia
- Hugh J. Gallen Career & Technical Ctr., Littleton
- Manchester School of Technology, Manchester
- Nashua Technology Center, Nashua
- Sugar River Valley RTC - Newport
- Plymouth Applied Technology Center
- Portsmouth Career Technical Center, Portsmouth
- R.W. Creteau Regional Technology Ctr., Rochester
- Salem HS Career & Technical Ed Ctr., Salem
- Lakes Region Technology Center, Wolfeboro

### Pre-Medical / Pre-Medical Studies

- Hartford Area Career & Technology Ctr., WRJ, VT

## NH COMMUNITY COLLEGE CONNECTIONS

		GBCC	LRCC	MCC	NCC	NHTI	RVCC	WMCC
Coaching						C		
Cyber Security & Health Care IT							A/C	C
Dental Assisting						C		
Dental Hygiene						A		
Diagnostic Medical Sonography						C		
Exercise Science				A				
Gerontology			C					
Health and Wellness Advocate								C
Health and Wellness Coach								C
Health and Wellness Facilitator								A
Health Information Management				A			A	
Health Information Technology			A					
Health Science				A		A		A
Legal Nurse Consultant						C		
Massage / Holistic Massage Therapy					A/C		C	C
Massage / Therapeutic Massage	C							
Medical Administrative Assistant	C	C	C				C	A
Medical Assistant			A				C	A
Medical Coding			C		C			C
Medical Laboratory Technician							A	
Nursing	A	A	A	A	A	A	A	A
Nursing - Advanced Placement Program		A	A			A	A	
Occupational Therapy Assistant							A	
Orthopaedic Technology						A/C		
Paramedic Emergency Medicine						A		
Personal Training			C					
Phlebotomy			C				C	C
Physical Therapist Assistant							A	
Radiation Therapy						A/C		
Radiography							A	
Radiologic Technology						A		
Respiratory Therapy							A	
Speech-Language Pathology Assistant					A			
Surgical Technology	A							
Veterinary Practice Management	C							
Veterinary Technology	A							

**APPENDIX 3: GOVERNOR'S COMMISSION EXECUTIVE SUMMARY**



**MARGARET WOOD HASSAN**  
Governor

**STATE OF NEW HAMPSHIRE**  
OFFICE OF THE GOVERNOR

**REPORT TO GOVERNOR HASSAN:**

**Recommendations on  
Health Care and Community Support Workforce**

**December 16, 2016**

The Governor's Commission on Health Care and Community Support Workforce

107 North Main Street, State House- Room 208, Concord, New Hampshire 03301  
Telephone (603) 271-2121 FAX (603) 271-7640  
Website: <http://www.nh.gov/> Email: [governorhassan@nh.gov](mailto:governorhassan@nh.gov)  
TDD Access: Relay NH 1-800-735-2964

**Table 1:**

**Membership**

**The Governor's Commission on Health Care and Community Support Workforce**

**Dr. Susan Huard**, Chair; President, Manchester Community College

**Kathy Bizzaro-Thunberg**, Executive Vice President of the New Hampshire Hospital Association

**Lisa DiMartino**, Parent of a child receiving long-term care services and support

**Jon Eriquezzo**, Vice President of Innovation of the Crotched Mountain Foundation

**Todd Fahey**, State Director of AARP New Hampshire

**Dr. Mike Ferrara**, Dean of the University of New Hampshire College of Health and Human Services

**Margaret Franckhauser**, Chief Executive Officer of Central New Hampshire VNA and Hospice

**Dr. Yvonne Goldsberry**, President of the Endowment for Health

**Brenda Howard**, Medication Nursing Assistant/Licensed Nursing Assistant at  
Maplewood Nursing Home of Cheshire County

**Dr. Judith Joy**, Interim Nurse Executive Director of the New Hampshire Nurses' Association

**Joelle Martin**, Council for Youths with Chronic Conditions Board Member

**Stephanie Pagliuca**, Director of Bi-State Recruitment Center

**Dennis Powers**, Chief Executive Officer of Community Crossroads

**Dr. Susan Reeves**, Dean of the Colby-Sawyer College School of Health Professions and  
Gladys A. Burrows Distinguished Professor of Nursing

**Deborah Scheetz**, Director, Integrated Health Care Reform of the New Hampshire Department of Health  
and Human Services

*The Staff of the Department of Health and Human Services provided exemplary support, assuring transparent access to information, as well as on-going administrative assistance to the Commission. Leslie Melby's support, as the Special Projects Administrator, is particularly appreciated.*

**Table 2:  
Individuals Who Gave Generously of Their Expertise**

<b>Date</b>	<b>Individual(s)</b>	<b>Organizations</b>	<b>Topics</b>
7/26/16	Stephanie Pagliuca Alisa Druzba Dr. Mike Ferrara Dr. Susan Reeves  Debbie Krider	Bi-State Primary Care Recruitment Center NH Dept of Health & Human Services UNH College of Health and Human Services Colby-Sawyer College School of Health Professions  Granite State Independent Living	NH Provider Vacancies State Loan Repayment Program Educational Opportunities for Health Care & Community Support Workforce Home Care Attendants
8/23/15	Gina Balkus  Dan Hebert	Home Care Association of New Hampshire  Consumer	Challenges in Home Health Staffing Personal Care Programs
9/27/16	Suellen Griffin Patrick Miller Chris Callahan  Peter Danles	West Central Behavioral Health and NH Community Behavioral Health Association Exeter Health Resources  NH Office of Professional Licensing and Certification	Behavioral Health Workforce Trends Medical Assistant Training Initiative Health Professions Licensing
10/25/16	Kristina Fjeld-Sparks Nancy Frank Paula Smith Trinidad Tellez, MD Shawn Barry Jessica Santos, PhD Brendan Williams Kathryn Kindopp	NH AHEC Program Office Northern NH AHEC Southern NH AHEC Office of Health Equity, DHHS Office of Health Equity, DHHS Institute on Assets & Social Policy, Brandeis Univ. NH Health Care Association Maplewood Nursing Home, NH Assoc. of Counties	New Hampshire Area Health Education Center NH Health Profession Opportunity Project  Long Term Care Facilities
11/22/16	Phil Przybyszewski	Workforce Solutions Project, Community College System of New Hampshire	NH Sector Partnerships Initiative

## EXECUTIVE SUMMARY

A robust health care workforce is essential to assure a stable health care system and a strong state economy. As the population of New Hampshire ages and becomes more diverse, citizen demands on the State's health care system are increasing. The Granite State is experiencing an unprecedented growth in demand for supports and services as its population ages. This is occurring just as the State is also experiencing an increasing rate of retirement among its supply of health care workers who are supporting children, adults and seniors. As a result of growing demand from aging baby boomers and a shrinking of the traditional caregiver labor pool, the future will be immeasurably worse without decisive action.

Today, New Hampshire faces a serious challenge in meeting its citizens' long term care needs in both community and facility-based settings. Workforce is not just an issue of concern to agencies or facilities, but to consumers and families. The State has identified shortages in critical healthcare fields that include: direct care provision, nursing (especially pediatric nursing<sup>1</sup>), psychiatry and other mental health professionals, physical therapy, geriatrics, and primary care. These shortages threaten the ability of New Hampshire's health care system to meet the emerging needs of our population, particularly for services delivered at the community level.

In April 2016, in recognition of the healthcare and direct support workforce shortage facing New Hampshire, Governor Margaret Wood Hassan issued an Executive Order creating the Commission on Health Care and Community Support Workforce. Comprised of experts from aging and developmental services, nursing, health professions education, primary care, community care, and facility services, the Commission was charged with assessing the scope of the problem and making recommendations to address the State's long term and short term health care workforce needs. Specifically, the Governor charged the Commission to do the following:

- a. Project the short- and long-term needs for health care and direct care workers in New Hampshire;
- b. Examine and recommend methods for recruiting additional health care and direct care workers;
- c. Examine and recommend additional steps as necessary to expand training opportunities and the training pipeline for health care workforce;
- d. Examine barriers to education and employment and recommend remedial approaches;

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<sup>1</sup> Final Report of the Commission to Study the Shortage of Nurses and Other Skilled Health Care Workers for Home Health Care Services and Post-Acute Care Services, SB 439, Chapter 252:1 Laws of 2016, November 1, 2016. Accessible online at <http://www.gencourt.state.nh.us/statstudcomm/reports/1277.pdf>

- e. Examine and make any recommendations for improvement on rate and pay structures that may prevent New Hampshire from attracting and retaining sufficient workforce to allow residents to receive high-quality care in their homes and communities;
- f. Identify any regulatory, credentialing or payment barriers to fully integrating care and support for those with chronic conditions living in the community;
- g. Examine and make any recommendations for improving rules, regulations or state laws that could help ensure New Hampshire residents have access to quality health and direct care; and
- h. Examine and make recommendations for any improvements to the structure of New Hampshire's loan repayment program and whether it is addressing current workforce needs.

Members of the Commission met monthly from May 2016 to November 2016, to discuss relevant publications, review data, and hear testimony from community stakeholders focused on workforce issues and concerns. Meetings were held May 31, June 28, July 26, August 23, September 27, October 25, November 22, 2016, and December 15, 2016 (via conference call). Meeting agendas in support of the Executive Order included expert testimony to identify the scope of the workforce shortage throughout the state, to identify recruitment and retention concerns, and to propose workable solutions. The Commission also solicited community input by encouraging public comment at each of its meetings and at its public listening sessions held during the autumn of 2016 (October 4 in Concord, October 5 in Portsmouth, October 14 in Keene, October 19 in Manchester, October 28 in Littleton, and November 17 in Nashua). The Commission maintained a webpage<sup>2</sup> to publicize its meeting schedule, regional public listening sessions, meeting agendas, and stakeholder presentations.

Testimony from industry experts, health care employers, consumers, and the public impressed the Commission with the urgency of the workforce shortage crisis in New Hampshire. The Commission learned from its regional public listening sessions and numerous stakeholder presentations that it has become increasingly difficult to recruit and retain workers at all levels of care in New Hampshire - whether for in-home care, long-term care facilities, or hospitals. The resulting lack of continuity of care is detrimentally impacting the health and safety of New Hampshire's citizens.

Long Term Services and Supports (LTSS) are provided on an ongoing basis to help people of all ages with disabilities, disease, and chronic conditions live independently and participate in their communities.<sup>3</sup> However, the State's effort to meet its citizens' long term care needs is hampered by the severe shortage of health care and direct support providers. Inpatient health care facilities are limiting admissions or cannot open due to staffing shortages. On a community level, needs cannot be met and people cannot be cared for adequately and safely because of critical shortages and high turnover of both licensed and unlicensed caregivers. In

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<sup>2</sup> Commission on Health Care and Community Support Workforce. Accessible online at: <http://www.governor.nh.gov/commissions-task-forces/health-care/index.htm>

<sup>3</sup> Manatt Health, *Trends in Reforming Medicaid's Long-Term services and Supports (LTSS) System*

behavioral health, waiting lists and delays in care contribute to the increasing rate of unresolved substance misuse problems.<sup>4</sup> Together, these unmet needs contribute to economic losses for the state as well as profound safety concerns for those who rely on timely care delivery. The growing need for health care providers is further evidenced by the most recent NH Employment Projections by Industry and Occupation report, which projects that 20-25% of all new jobs needed over the next decade, will be in the healthcare sector.<sup>5</sup>

Based on the information collected by the Commission, including testimony, data and review of relevant materials, the Commission proposes the following solutions to better address the current workforce shortage and impending workforce crisis in health care and direct support providers:

- Reduce government barriers and delays related to the State's Licensure approval and criminal background checks;
- Create a robust mechanism to collect capacity data of the current health care workforce and use that data to project future health care and direct support workforce needs;
- Continue to enhance current educational programs, develop new and innovative training programs, and enhance retraining programs; and
- Raise Medicaid reimbursement rates to support wages that reflect the current and competitive wage scale for a healthy economy in New Hampshire.

The Commission's findings are focused on the following priority areas:

1. **Licensure and Certification:** Issues around the State's professional licensure and certification rules and regulations arose early and repeatedly in testimony submitted to the Commission. It is apparent that the variety of licensure rules and differing processing regulations and practices create inconsistencies and inefficiencies in staff recruitment and on-boarding new workers by health care and support services providers. In the State's current economic environment, in which some health care worker wages are not competitive, delays in license processing are resulting in the loss of potential workers to other employment. Licensure rules also hamper billing for some services. In some cases, licensure actually prevents a qualified, vetted worker from providing services.
2. **Direct Support Professionals:** New Hampshire is experiencing a growing shortage of direct support professionals, which threatens the ability of individuals to remain in their homes and communities. Direct support professionals provide critical supports and services without which the State's policy to strengthen its Long Term Services and Supports will

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<sup>4</sup> As of August 2016, there were 173 vacant postings solely within NH's community mental health centers. This represents \$6.8-7.6 million in wages not entering the state's economy. *Workforce Trends, Impacts and Solutions*, NH Community Behavioral Health Association. Accessible online at <http://governor.nh.gov/commissions-task-forces/health-care/documents/hc-09-27-2016-community-behavioral.pdf>

<sup>5</sup> New Hampshire Department of Employment Security, *NH Employment Projections by Industry and Occupation, base year 2014 to projected year 2024*, June 2016. Accessible at <http://www.nhes.nh.gov/elmi/products/proj.htm>

likely not be achieved. In New Hampshire, direct support providers are plagued by low wages and poor benefits. The Commission heard repeated pleas for increased provider rates so that direct support providers can achieve a livable wage at hourly rates that recognize their level of responsibility, heavy workload, and high injury rates. The Commission calls attention to this workforce shortage area separately since unlicensed workers are an integral component of the support system.

3. **Data Collection and Analytics:** There is a paucity of data to document the size and capacity of the current health care workforce in New Hampshire, and to identify future workforce needs of the population. The Commission found that useful data on the healthcare and direct support workforce are scarce and, when available, are of poor quality. Discussion regarding the barriers to useful data collection pointed to the State's long tradition of privacy and reluctance to gathering and analyzing what some feel may be personal information. In addition, resources to analyze and disseminate data within the State are underfunded. Planning and decision making for future needs is exceptionally hampered by lack of meaningful historical and current data, and the lack of a state data analytics function to support gap analysis and predictive modeling.
4. **Education and Training:** Quality education supporting the health care and direct support workforce is available in the State, but elements are underutilized for a variety of reasons. Successful programs to support educational advancement at all health care provider levels have been developed in the State using grants and other funding sources, only to be terminated for lack of ongoing financial support. This, among other factors, has led to a shortage of training programs at the direct care provider, licensed nursing assistant, and practical nurse levels.

In addition, significant challenges are manifest into the foreseeable future as faculty retire and prospective faculty choose not to teach. At all levels of education, however, cost is a barrier for career development and advancement. The mismatch of costly educational preparation for an academic career and salary has also created a barrier for faculty recruitment, as salaries for educators often compare poorly to salaries for clinical practice. Given the aging of the faculty workforce, a critical shortage of academically prepared faculty is already taking place and anticipated to worsen.

For students who are able to find appropriate education, effective transition to work is also compromised. Internships and apprenticeships in clinical facilities and in the community are scarce, and are leading to a delay in the development of "career ready" personnel. The shortage of opportunities for transitional education not only impacts quality of care directly, but also contributes significantly to role satisfaction, workforce recruitment, and workforce retention.

5. **Financial Supports:** Financial considerations are threaded throughout the Commission's findings and recommendations. However, one theme repeated throughout Commission deliberations was the failure of Medicaid provider reimbursement rates to keep pace with

cost of living. Medicaid reimbursement has been stagnant for many years, thereby suppressing wage growth. Non-competitive wages have created high turnover in direct service providers and skilled nurses caring for seniors and individuals, inclusive of children, with disabilities in their homes. Behavioral health and substance use disorder treatment providers have similarly been impacted with wage disparities, thus discouraging potential providers from entering the workforce.

An additional theme relates to the shared border with Massachusetts and its capital, Boston. The appeal of higher salaries, as well as the social atmosphere of a large city, is a factor in retention for many New Hampshire communities near the border and in rural areas of the State. The need to revitalize community life or present vital community environments that already exist to potential workforce was noted. Closely related was the need to consider improvements in reciprocity as a mechanism for future recruitment. Many individuals currently holding a license from another state who have sought licensure in New Hampshire, report that the requirements for reciprocity are too cumbersome for someone with experience/licensure.

The prevailing purpose of the Commission's recommendations is safety for the State's citizens. It is important to note that quality and safety concerns are implicit when examining health care workforce shortages. A shrinking workforce to serve a growing number of patients in community settings results in service access problems that seriously compromise the availability and quality of care.<sup>6</sup> (See Appendix C, *Final Report of the SB 439*.<sup>7</sup>)

The Commission's work initiated a process of investigation that revealed a number of salient problems and solutions. However, a number of workforce issues remain for which this Commission did not have sufficient time to investigate. Therefore, the Commission has identified priority workforce issues for future consideration by the State's policymakers.

Unfortunately, there is no silver bullet that can solve today's shortages and meet future demand. Actions are required at many levels, on many different fronts. Confronting workforce shortages is inextricably related to all other aspects of acute health care and long-term care reform—from defining what the long-term care system is expected to do and how it should be financed, to how to promote quality, employ technology, and develop and implement new models of organization and service delivery. How New Hampshire chooses to meet the growing demand for long-term care in the future will have a significant impact on the number and types of personnel that will be needed, from where they will be recruited, how they should be compensated and trained, the nature of their work and the settings in which they work.

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<sup>6</sup>NH Community Behavioral Health Association, *Workforce Trends, Impacts and Solutions*, September 27, 2016. Accessible online at <http://www.governor.nh.gov/commissions-task-forces/health-care/documents/hc-09-27-2016-community-behavioral.pdf>

<sup>7</sup>*Final Report of the Commission to Study the Shortage of Nurses and Other Skilled Health Care Workers for Home Health Care Services and Post-Acute Care Services*, SB 439, Chapter 252:1 Laws of 2016, November 1, 2016, Accessible online at <http://www.gencourt.state.nh.us/statstudcomm/reports/1277.pdf>

Members of the Governor's Commission on Health Care and Community Support are honored to have participated on the Commission and respectfully submit this report for the Governor's consideration and implementation. Following is a summary problem definition with associated short and long term recommendations to improve the health care workforce landscape in New Hampshire to better meet the need of its citizens, and proposed viable solutions to address these problems.

# Who will provide integrated care?

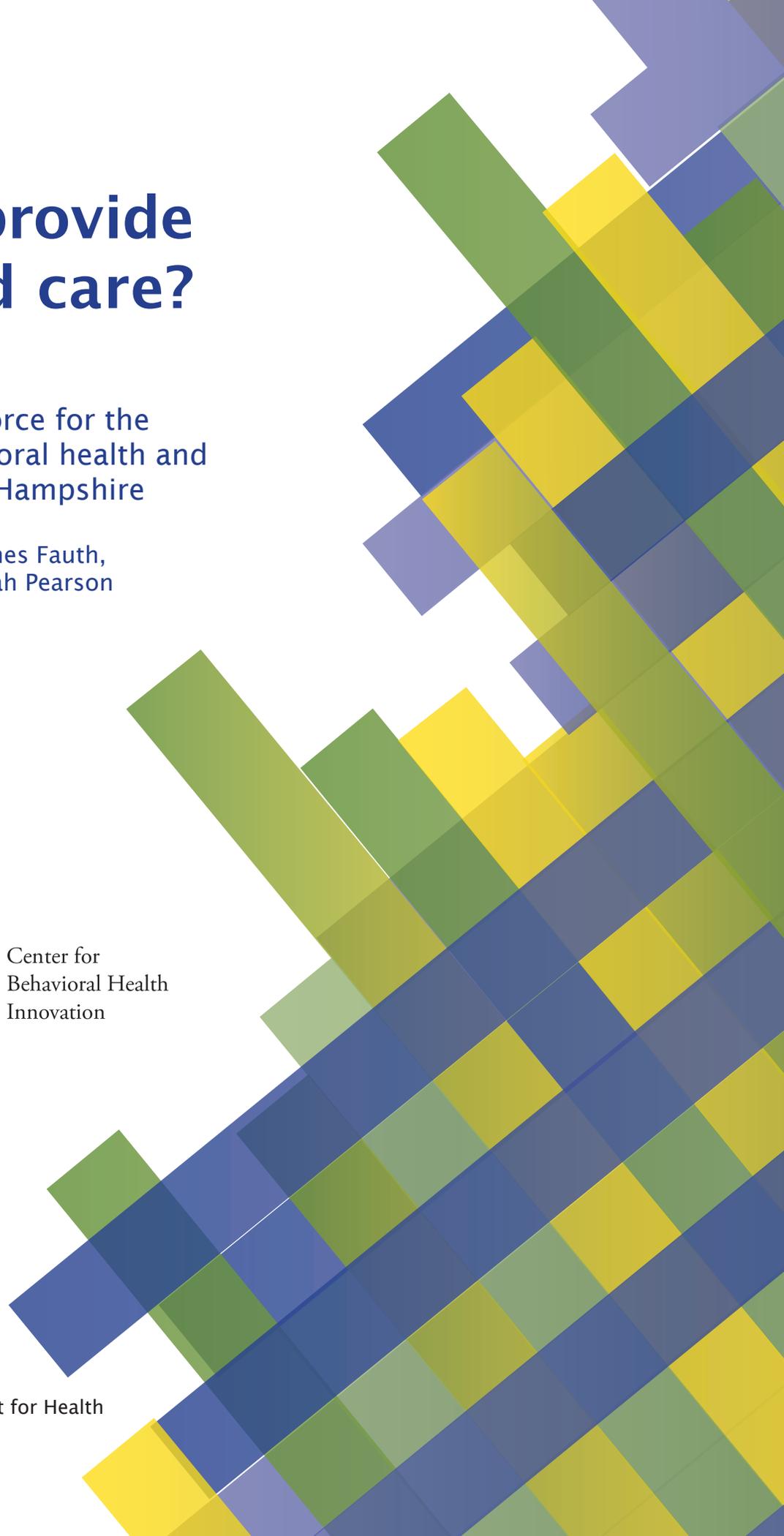
Assessing the workforce for the  
integration of behavioral health and  
primary care in New Hampshire

Alexander Blount, James Fauth,  
Anne Nordstrom, Sarah Pearson

**ANTIOCH**  
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NEW ENGLAND

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Innovation

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Antioch University New England is part of Antioch University, a five-campus university (Antioch University New England, in Keene, NH; Antioch University Midwest (formerly McGregor) in Yellow Springs, Ohio; Antioch University Seattle in Seattle, Washington; and Antioch University Los Angeles and Antioch University Santa Barbara in California).

**The Center for Behavioral Health Innovation** shoulder-to-shoulder with community partners to improve behavioral health practice for underserved populations in New England and beyond.

[antiochne.edu](http://antiochne.edu)

## Workforce Advisory Team

Sharon Beaty: *Chief Executive Officer, Mid-State Health*

Peter Fifield: *Behavioral Health Clinician, Families First Health Center*

Carol Furlong: *Vice-President, Operations at Harbor Homes in Nashua*

William Gunn: *Assistant Professor of Community and Family Medicine, Dartmouth College*

Jeanne Ryer: *Director, Citizen's Health Initiative*

Will Torrey: *Professor of Psychiatry, Professor of The Dartmouth Institute*



The Endowment for Health is a statewide, private, nonprofit foundation dedicated to improving the health of New Hampshire's people, especially those who are vulnerable and underserved. We envision a culture that supports the physical, mental, and social wellbeing of all people – through every stage of life. Since 2001, the Endowment has awarded more than 1,100 grants, totaling more than \$44 million to support a wide range of health-related programs and projects in New Hampshire.

[endowmentforhealth.org](http://endowmentforhealth.org)

# Who will provide integrated care?

## Assessing the Workforce for the Integration of Behavioral Health and Primary Care in New Hampshire

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# Executive Summary

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## **This study fills knowledge gaps about the integrated primary care workforce**

The Cherokee (2014) report identified workforce as a primary barrier to the successful integration of behavioral health (IBH) in primary care settings in New Hampshire (NH). This study, conducted by the Center for Behavioral Health Innovation at Antioch University New England, picks up where the Cherokee report left off by filling knowledge gaps about workforce needs, assets, and potential directions. We hope to provide information and vision necessary to inform the development of a strategic and effective NH IBH workforce plan.

## **The IBH workforce in primary care was broadly defined**

We defined the IBH workforce broadly to include the roles that serve a number of behavioral health-related functions, including prescribing and consulting about psychotropic medications, providing psychosocial interventions, enhancing patient engagement in care, supporting health literacy and adherence, addressing barriers to health and healthcare (i.e., social determinants of health), and keeping information flowing between the patient and the primary care team.

## **We assessed the IBH workforce from the perspectives of primary care practices and training programs**

We assessed the perspectives of primary care practices – with an emphasis on safety net providers – and potential IBH training institutions and programs. We assessed primary care providers with an online survey; 71% of safety net clinics responded. We also reached out to all NH-based training programs that might conceivably contribute to the IBH workforce of the future. We assessed training institutions with a phone-based interview; 40% of the training programs participated.

## **Providers and training programs are enthusiastic, but in early stages of development**

Safety net providers expressed broad interest in IBH. The current levels of integration and the organization of programs indicate a service system in the early stages of integrated care, while underestimating the progress yet to be made to realize that goal. Academic programs are not, as a rule, considering work in primary care as a primary destination for their students at the doctoral, master's, bachelor's or associate's level. Most training programs, however, are interested in learning more about how they might contribute to the IBH workforce of the future.

## The most central IBH workforce roles are most difficult to fill

Four critical primary care behavioral health workforce roles emerged from the safety net provider input: 1) consulting psychiatrists and psychiatric prescribers, 2) behavioral health clinicians, 3) primary care clinicians (also called primary care providers), and 4) staff that augment care and communication between patients and providers, which we are calling “care enhancers.” While we did not survey the primary care clinician workforce, the literature shows their contribution to be crucial to successful IBH. The most central roles in IBH – psychiatric consultants and behavioral health clinicians – are perceived as the most difficult positions to fill. A desire was expressed for more “substance abuse counselors.” We believe substance-related interventions should be subsumed under the – generalist – “behavioral health clinician” role and that BHCs should be trained to be competent to perform this function at a generalist level.

## Doorways and pathways towards the primary care IBH workforce of the future

The next step in developing the IBH workforce for the future of primary care is to bring primary care providers and training programs of academic and CME organizations together to create and implement a NH IBH workforce development plan. The plan should build on the “doorways and pathways” and pre- and/or post- graduate training models discussed in this report, to enhance the number, quality, and diversity of care enhancers, psychiatric consultants/prescribers, and behavioral health clinicians who are well prepared to deliver IBH in NH.

## Introduction

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Behavioral health conditions exact staggering burdens on individuals, families, and societies alike (Kessler et al., 2005; Kessler et al., 2009). Although effective treatments exist, most people with behavioral health conditions (mental health, substance abuse or serious health behavior change needs) neither seek nor receive adequate treatment (Kessler et al., 2005). Of those who do, most seek help in primary care settings that consistently under-detect and under-treat behavioral health conditions (Coyne, Thompson, Klinkman, & Nease, 2002; Mertens, Lu, Parthasarathy, Moore, & Weisner, 2003; Schulberg, Block, & Madonia, 1996). Experts have advocated for the integration of behavioral health (IBH) into primary care settings as the most effective way to close the behavioral health treatment gap (World Health Organization, 2008). Numerous randomized clinical trials indicate that IBH can enhance the detection, uptake, effectiveness, and cost effectiveness of behavioral health care in primary care settings (Butler et al., 2008; Blount, 2003).

Widespread, effective, and financially sustainable implementation of IBH has proven very challenging in settings of usual primary care (Alexander, Arnkoff, & Glass, 2010; Pincus, 2003). Among the barriers to successful dissemination and translation of IBH has been a limited and poorly equipped workforce. National estimates indicate that the behavioral health workforce is insufficient to meet the need of patients in our safety net primary care settings (Burke et al., 2013). The problem extends beyond the limited pool of behavioral health providers, to inadequate preparation of each group on an integrated health team. The current behavioral health and primary care workforce lacks the training, acculturation, skills, attitudes, and leadership qualities

---

necessary to successfully work as a team to enact IBH (Workforce / SAMHSA-HRSA, n.d.). Limited didactic and experiential training opportunities continue to hamper the dissemination and implementation of IBH (Hall, Cohen, Davis et al., 2015).

For the population with serious mental illness or serious substance abuse disorders (SMI), it would seem that the problem to be addressed by integration is their physical health. People coping with SMI have health problems that parallel their SMI problems in intensity, making them extremely vulnerable to loss of function due to chronic illness and to early death (Coulton & Manderscheid, 2006). One approach to addressing this problem has been to bring primary care services into behavioral health centers. While the problems of “reverse integration” are somewhat different from primary care IBH, the training needs for staff are similar. Add the fact that almost 1/3 of people coping with SMI get all of their care, medical and behavioral, solely in primary care medical settings (Wang, et al, 2006), and it is clear that the training conclusions of the report, that IBH workers be trained in addressing chronic illness, health behavior issues, mental health and substance abuse needs can be applied to the entire workforce for integration.

A recent report commissioned by the Endowment for Health and conducted by Cherokee Health Systems highlighted the perception among key stakeholders that NH lacks an adequate IBH workforce (Cherokee Health Systems, 2014). Respondents highlighted a lack of qualified behavioral health clinicians, a confusing licensing environment, a shortage of psychiatry, and an overall aging workforce, as major impediments to IBH. Workforce shortages and inadequate preparation extended to the primary care/medical workforce as well. The aforementioned problems are further compounded by the lack of adequate specialty mental health care and the rural nature of many NH communities. The former places heavier behavioral health burdens on primary care practices, while the latter makes it difficult to recruit, train, and retain qualified professionals.

The Cherokee (2014) report advocated for a multi-pronged workforce development strategy, including but not limited to developing a statewide workforce plan that articulates the number and types of workforce needed, considering ways to expand the workforce pipeline, and advocating for policy changes to support workforce development. While the Cherokee (2014) study identified workforce, practice transformation, and payment reform as interlocking barriers to IBH, it stopped short of investigating and documenting workforce needs, assets, and potential role development in the depth necessary to inform effective strategic action.

This project was designed to fill IBH workforce-related knowledge gaps, to inform a NH IBH workforce development plan. First, we sought to better understand the current and future workforce needs of primary care settings, with a focus on safety net providers (i.e., Federally Qualified Health Centers, Rural Health Clinics). Second, we assessed the extent to which NH-based training institutions are preparing their students for IBH roles in primary care. Finally, we leveraged the scholarly literature, the Cherokee report, and our findings to develop a NH-based IBH workforce development plan.

# Method

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## Stakeholder Engagement

The project was conducted by the Center for Behavioral Health Innovation (BHI) at Antioch University New England. BHI works shoulder-to-shoulder with community partners to improve behavioral health practice for underserved populations, through behavioral health integration, knowledge translation, evaluation, external facilitation, and technical assistance. The principal investigator for the project (Blount) is a nationally recognized IBH thought leader.

We developed a Workforce Advisory Team (WAT) to provide input and consultation to the project. It consisted of key IBH stakeholders, from a variety of roles within safety net settings, with the New Hampshire Behavioral Health Integration Learning Collaborative and training/academic programs represented, as well. See the beginning of this document for the members of our Workforce Advisory Team.

We met with the WAT twice, the first time for input into the survey methodology and the second time for help with data interpretation and reporting. At the first meeting, the WAT described the landscape of IBH in New Hampshire from their perspective, and the wide varieties of roles and staff that occupy a place within that landscape. We were told the following:

- Practices need information about how to select IBH staff
- Most IBH training is “on the job”
- Little career mobility exists between roles
- Few common standards exist for defining IBH roles across clinics

We met for the second time with the WAT after collecting and analyzing the data, to get their assistance with interpreting the data. The team confirmed our understanding of the data, that most primary care clinics are not as integrated as they think they are, although clinics have evolved somewhat in the two years since the “Cherokee Report” was released. The WAT validated our understanding of the basic IBH roles that we perceived in the data. WAT also supported, in broad strokes, a formative version of the conclusions and recommendations contained in this report.

## Primary Care Needs Assessment

We conducted an IBH workforce needs assessment, via a brief online survey sent to NH primary care practices (with a focus on safety net providers). We did not assess the number or role of primary care clinicians (PCCs) in our survey; i.e., family medicine, internal medicine and pediatric physicians, nurse practitioners and physician assistants. The PCC workforce has been addressed by others and is tracked nationally.

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Instead, we inquired in the survey about all staff who were perceived by the WAT as contributing to the delivery of behavioral health services, broadly defined, in primary care. These contributions include:

- Prescribing and consulting about psychotropic medications
- Providing psychotherapeutic interventions
- Creating and maintaining patient engagement in care
- Addressing health literacy, adherence, and health barriers (i.e., “social determinants of illness”)
- Keeping information about the patient’s health needs and health behavior flowing between the patient and the health team

The survey inquired about current and projected staffing for behavioral health functions, the readiness of new and current staff to perform behavioral health aspects of their roles, and the difficulty of finding qualified persons to fill each role. The survey also asked respondents about the current level of integration at their site. See Appendix A for the full needs assessment survey.

We focused on surveying safety net providers, since they have the mandate – and access to additional resources – to care for our most vulnerable, underserved, and psychosocially challenged patients. As such, these health centers are likely to be early adopters of IBH and acutely aware of IBH-related workforce supply, demand, and quality issues.

While our sample is small and focused on one segment of the overall primary care patient population in New Hampshire, there has been enough experience in integrating care for all populations to be able to use our findings to get a picture of the needs statewide. The AIMS Center of the University of Washington, the leader in the development of the Collaborative Care Model of IBH, estimates that the staffing level for behavioral health clinicians for complex, multi-condition low income populations needs to be up to three times that required to serve populations with adequate incomes who have behavioral health or medical needs only.

We worked with the Endowment for Health, Bi-State Primary Care, and NH DHHS to identify safety net providers in the state (i.e., Federally Qualified Health Centers and Rural Health Clinics). The Executive Directors of each safety net provider clinic received an electronic cover letter and short questionnaire, and two weeks later a follow-up reminder if they had not yet completed the questionnaire. The Workforce Advisory Team members also reminded the Directors to participate. Of the 21 providers identified, 15 completed the survey, for a 71% response rate. We also identified nine Dartmouth-Hitchcock clinics that provide primary care and serve a large number of Medicaid patients. We telephoned and emailed the Practice Managers and/or Medical Directors, asking for their participation. After several follow-up attempts, only one of the 9 clinics completed the survey, so we restricted our analysis (and interpretation) to the data provided by the safety net providers. See Appendix B for the list of clinics.

## Training Program Asset/Desire Assessment

In parallel with the needs assessment, we conducted a workforce asset/desire assessment, to identify NH's current and potential future IBH workforce training offerings. The search included both higher education institutions and other types of training programs that prepare individuals to enter the workforce with skills under a particular degree and/or certification. Because our definition of IBH was inclusive, we identified a wide range of potentially relevant academic and other training programs, including graduate level psychology and counseling programs; family medicine and psychiatry residencies; and associate's, bachelor's and master's programs in social work, nursing, physician assistant, medical assistant, occupational therapy, human services, community health worker and public health.

In total, we identified 30 training institutions, offering 95 academic degrees and/or programs. Emails and/or phone calls were made to a representative of each program, with a brief description of the project and an invitation for them to participate in the study by completing a short interview. Of the 95 training programs, 42 (44%) did not respond, 15 (16%) declined to participate or indicated that IBH was not relevant to their program, and 38 (40%) completed the phone-based interview protocol. See Appendix C for the list of training programs.

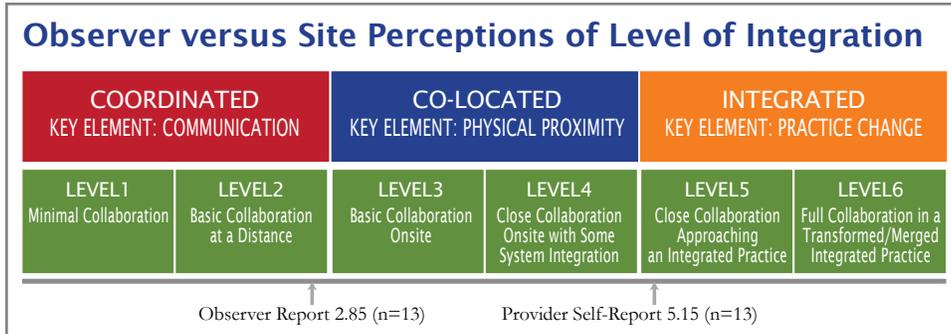
The interviews asked respondents about the settings in which their graduates have been placed, including primary care. The interviews also inquired about experiential and didactic training offerings specific to behavioral health in primary care. We asked each site about their interest in focusing more on this area of training in the future, and collected some basic information about each program. See Appendix D for the phone-based interview protocol.

Our research team (three Clinical Psychology faculty, one staff evaluator, one doctoral level Clinical Psychology student) quantified responses to four of the interview questions. Questions about program graduates' training and placement were scored on a three-point scale: 0 = No behavioral health or primary care training, 1 = behavioral health OR primary care training (but not both), and 2 = primary care behavioral health (i.e., IBH training). Questions about programs' interest and readiness to focus intentionally on primary care behavioral health training expansion in the future were also scored on a three-point scale: 0 = pre-contemplation (i.e., unaware of the opportunity or disinterested), 1 = contemplation (i.e., some awareness of the opportunity, willing to think more about it) and 2 = ready to act (i.e., aware of the opportunity and ready to take action). All five members of the research team read the interview transcripts and scored the responses using the aforementioned scales. The average score across all five raters was used in subsequent analyses.

# Findings: Primary Care Needs Assessment

## Safety Net Providers View Themselves as More Integrated than Observers

We asked respondents to self-report their level of integration on SAMHSA’s six-point scale (see graphic, below). They rated themselves at about level 5 on average – the “close collaboration approaching integration” level. This finding stands in contrast to the independent ratings of Cherokee Health Systems a couple of years earlier, which would have placed these same practices somewhere between levels 2 (basic collaboration at a distance) and 3 (basic collaboration onsite). Consistent with research (Hall et al., 2015) and input from our Workforce Advisory Team, our impression is that the Cherokee assessment is probably the more accurate



representation of the level of integration among our respondents. The tendency to overestimate one’s degree of integration is almost universal, especially once a behavioral health clinician has been added.

## From chaos, a few fundamental role categories emerge

A dizzying array of staff roles and titles are in use by our respondents, with considerable variation in how these roles and titles are perceived and filled across sites. Based on the scholarly literature and input from WAT – as well as our desire to bring more coherence to these data – we have conceptualized these roles as falling within four categories: behavioral health clinicians (BHCs), primary care clinicians (PCCs), consulting psychiatric clinicians

**IBH Roles, Conceptualized**

<b>BCH (Behavioral Health Clinician)</b>	• Master Social Work, Doctor Philosophy/Doctor Psychology, Mental Health Counselor, Marriage Family Therapist, Substance Abuse Counselor
<b>CPC (Consulting Psychiatric Clinician)</b>	• Psychiatric Medical Doctor/Osteopathic Doctor, Psychiatric Nurse Practitioner, Psychiatric Advanced Practice Nurse, Psychiatric Physician Assistant
<b>CE (Care Enhancer)</b>	• Bachelor Social Work, Medical Assistant, Care Manager, Care Coordinator, Health Coach, Community Health Worker, Patient Educator, Patient Advocate, Navigator, Registered Nurse, Bachelor Science Nurse

(CPCs), and other members of the healthcare team which we are combining under the title of Care Enhancers (CEs). See the figure at left for how we operationalized these role categories. Note as well, that we use this categorization repeatedly, throughout the remainder of this report.

## IBH staff perceived as corresponding to IBH roles; Most receive on-the-job training

We asked our safety net respondents about who actually fills various IBH-related roles now, and who they would like to fulfill those roles now and in the future. As reflected in the table below, most respondents are satisfied with how they fill the various IBH-related roles now. They don't anticipate drastic changes in who will make up the IBH workforce of the future. The exceptions to this rule are that respondents would like to have bachelor's level social workers (BSWs) filling the care manager role of the future, rather than the registered nurses (RNs) and bachelors of science in nursing (BSNs) that tend to occupy it now. Some of the Care Enhancer roles we assessed do not exist in most of the clinics surveyed. Depending on which role they were using, our respondents generally wished for their CE roles to be filled by registered nurses or BSN, or staff with other Bachelor's or Associate's degrees.

We also asked our respondents where most of these staff get trained to fill the IBH aspects of their role – whether they perceive them as “ready to go” (i.e., not requiring any additional training once their graduate training is completed), whether they need to receive “on-the-job-training” (OJT) to meet the demands of their role, or whether they require substantive additional training from external sources. Most clinics perceive staff as either ready to go, or needing on the job training. Additional training from external sources for staff to fulfill their IBH role is rare, despite the findings in the literature that such training is necessary and

can make the difference between success or failure of an IBH program (Hall, Cohen, Davis, et al., 2015). Our respondents' lack of exposure to IBH workforce members who have had specific training for primary care behavioral health, is consonant with our perception that most do not have highly specific conceptualization of the clinical roles and routines of IBH, and are therefore at risk of failing to appreciate the additional training needs of their current workforce.

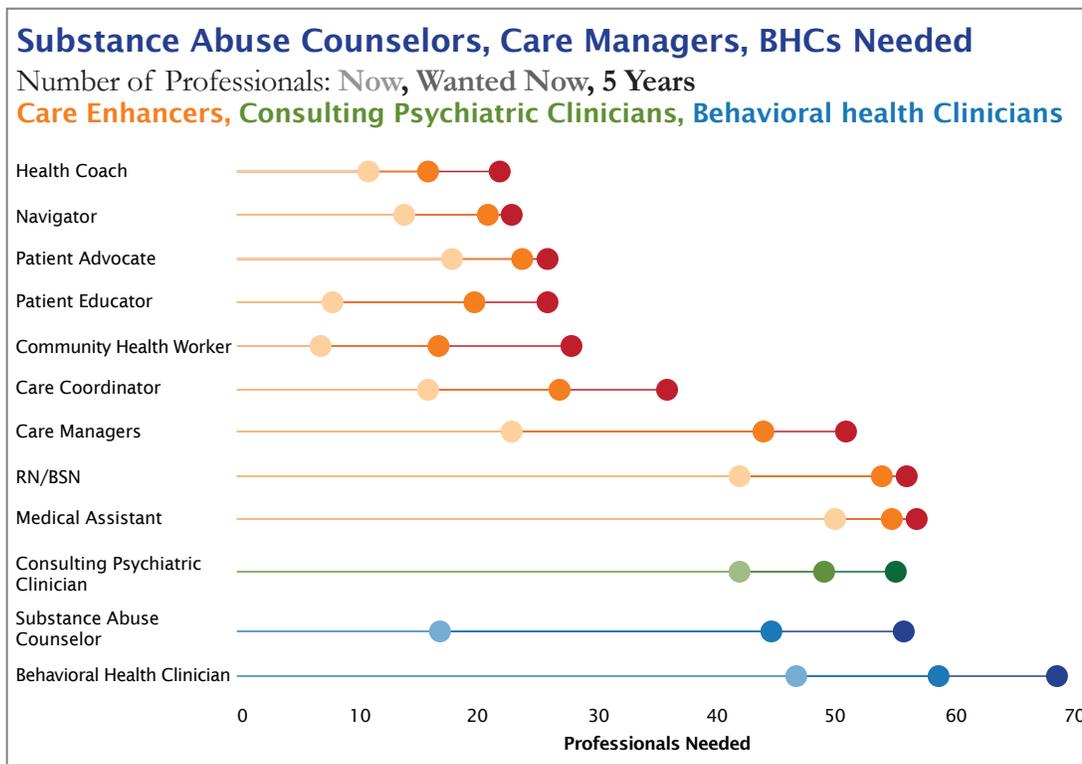
Role Category	Role	Who is filling the role now? (mode)	Who would you <i>like</i> to fill the role? (mode)	Where Trained? (mode)
Care Enhancers	Care Coordinators	RN/BSN	RN/BSN	OJT
	Care Managers	RN/BSN, followed by “ <i>don't have this role</i> ”	BSW	OJT
	Medical Assistants	Medical Assistant	Medical Assistant	OJT
	Patient Educators	“ <i>don't have this role</i> ,” followed by RN/BSN	RN/BSN	OJT
	Health Coach	“ <i>don't have this role</i> ,” followed by RN/BSN	RN/BSN	RTG=OJT
	Nurse	RN/BSN	RN/BSN	RTG
	Patient Advocate	Other Bachelor's	Other Bachelor's	OJT
Behavioral Health Clinicians	Navigator	“ <i>don't have this role</i> ,” followed by Other Bachelor's	Other Bachelor's or Associate Degree	OJT
	Substance Abuse Counselors	MSW	MSW, followed closely by LMHC	RTG
Consulting Psychiatric Clinicians	BH Clinicians	MSW	MSW	RTG
	Psych Consultants & Prescribers	NP/APN, followed by MD/DO	NP/APN, followed closely by Psych MD/DO	RTG

Abbreviation Key: RN=registered nurse; BSN=bachelor of science in nursing; MSW=master of social work; LMHC=licensed mental health counselor; NP=nurse practitioner; APN=advanced practice nurse; MD=medical doctor; DO=osteopathic doctor; OJT=on the job training; RTG=ready to go

## Substance abuse counselors, care managers, behavioral health clinicians in demand

Respondents were asked to report the number of staff in each of the various IBH roles now, as well as how many they would like to have now and in the future. The chart below reflects their answers. The color of the circle represents the role category (Care Enhancer, Consulting Psychiatric Clinician, or Behavioral Health Clinician). The dark, left-hand circle represents the current number of staff filling each role; the moderately shaded, middle circle represents the number they wish they had now; and the light, right-hand circle represents the number they wish to have in five years. The gap between the left-hand circle and the middle circle reflects current demand for that role, and the gap between the left- and right-hand circles reflects the projected “five-year” demand for that role.

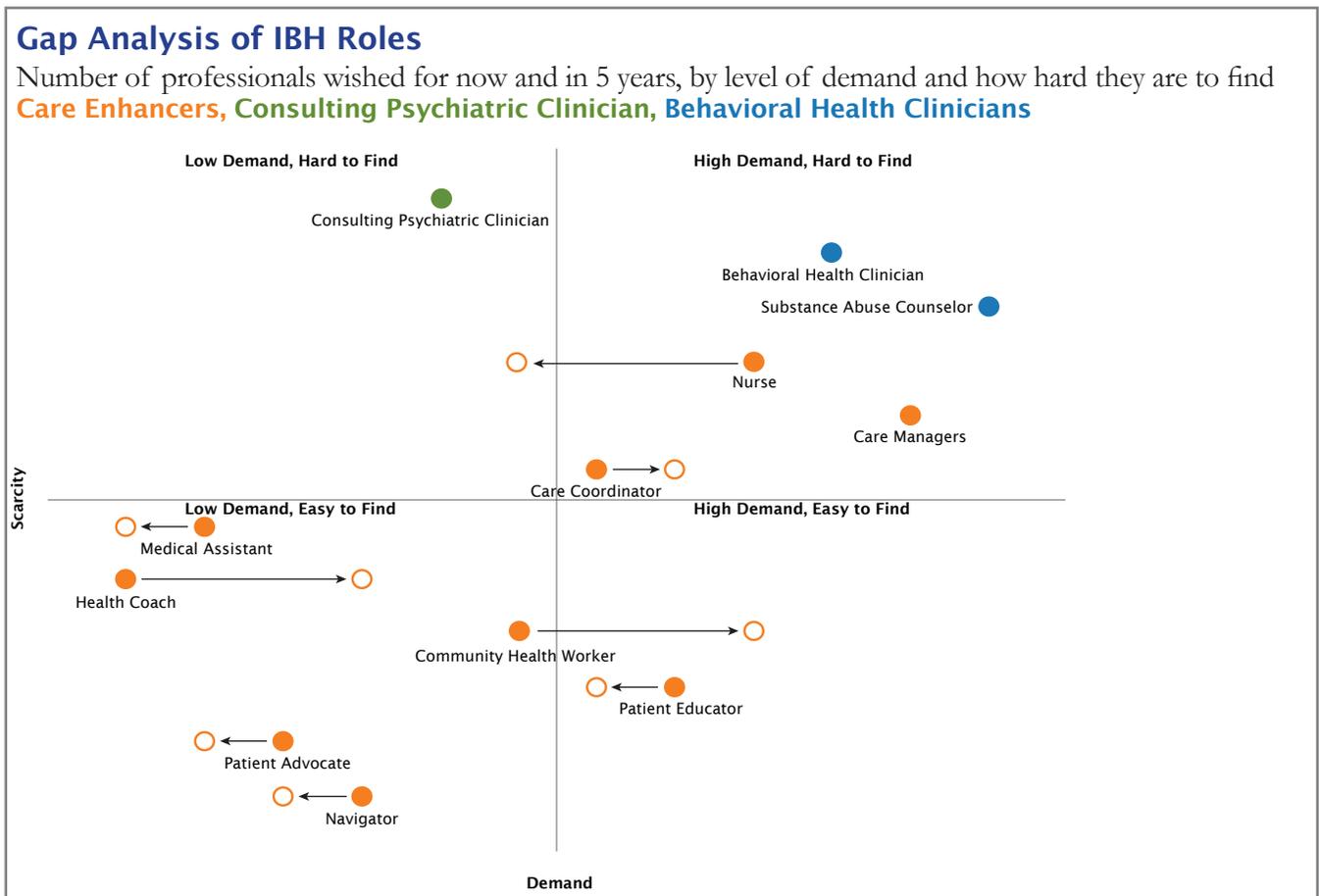
Considerable variability exists in the current number and future demand for the various Care Enhancer roles. The current number and projected current/future demand for health coaches, patient navigators, and patient advocates are limited. The current number of patient educators, community health workers, care coordinators, and care managers is also relatively low, and substantially discrepant from anticipated future demand. Finally, registered nurses and medical assistants (who, with additional training, can be part of the IBH behavioral health workforce) are ubiquitous now, and are likely to remain so in the future. Respondents are currently most lacking in substance abuse counselors, wishing to have many more both now and in the future. Those professionals who more typically fill the behavioral health clinician role (psychologists, social workers, counselors) are more common, with moderate growth in demand projected into the future. The current number of consulting psychiatric clinicians is fairly high, with moderate projected growth in demand.



## IBH roles most in demand are also hardest to find

We asked respondents to rate how difficult it is to find adequately trained staff to fulfill the behavioral component of each of the IBH roles, from 1 (very easy) to 5 (very difficult). By layering that information with the information about current and future demand, we created an IBH workforce gap analysis chart. This chart places the perceived demand for each IBH role on the X-axis, and the difficulty filling each role on the Y-axis. Splitting each axis at its mid-point created four quadrants: 1) high demand, hard to find; 2) high demand, easy to find; 3) low demand, easy to find; and 4) low demand, hard to find. As in the previous chart, color-coding reflects roles, with Care Enhancers in orange, Behavioral Health Clinicians in blue, and Consulting Psychiatric Clinicians in green. The solid circles reflect the “wished for now” rank order placement on the Demand and Difficulty Finding dimensions, and the hollow circles reflect the “wished for in five years” placement. The arrows represent the direction and magnitude of change in demand, from now to five years. When no difference exists between the “wished for now” and “wished for in five years” rank order, only a single solid circle is visible.

IBH workforce development should focus on those roles in the “high demand, hard to find” quadrant: behavioral health clinicians, substance abuse counselors, case managers, care coordinators and nurses. All of these roles are in demand now, and expected to remain so in coming years, except for nurses, where demand is expected to drop a bit moving forward. Consulting psychiatric clinicians are also moderately in demand and very hard to find. This finding is also important, given the centrality of consulting psychiatric clinicians to successful IBH practice in primary care.



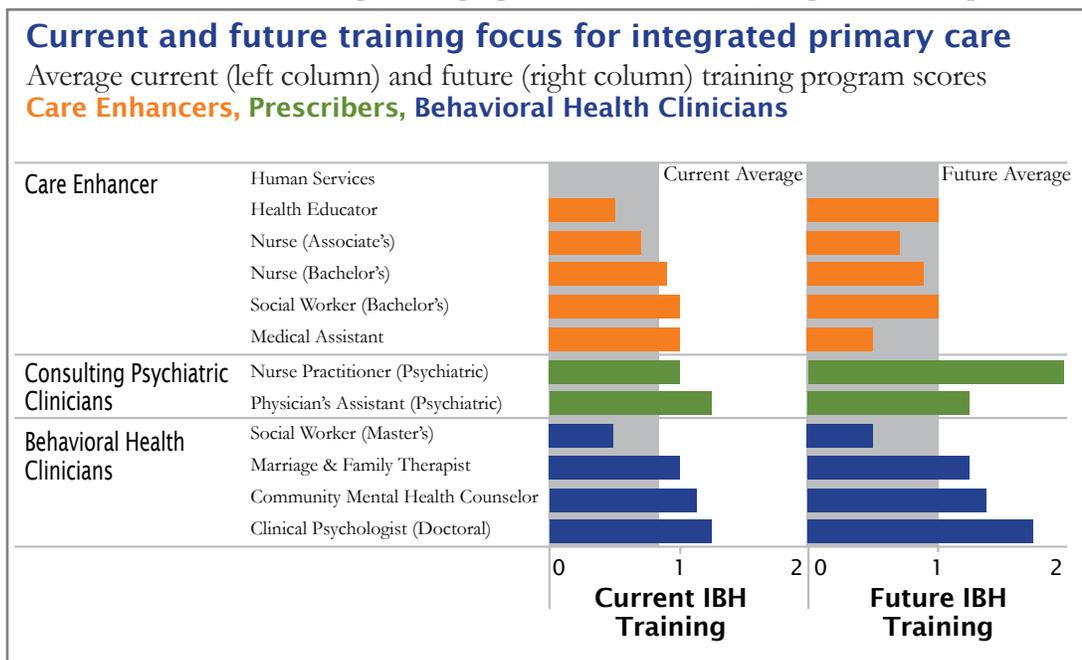
# Findings: Training Program Asset/Desire Assessment

## IBH-related training in New Hampshire is in its infancy

Many training programs expressed interest in preparing their graduates for relevant IBH roles, but most have not yet done so in a systematic or deliberate manner. As reflected in the first set of bars in the chart below, most programs offer either behavioral health training or primary care training, but not IBH training (0=neither primary care nor behavioral health training; 1=behavioral health or primary care training; 2=IBH in primary care training). Nationally, the most advanced training programs for BHCs offer coursework and/or experiential IBH training opportunities in primary care. Graduates from these programs are prepared to assess patient behavioral health needs, develop plans of care, implement or augment medical regimens, evaluate the effectiveness of regimens and motivate individuals to change unhealthy habits. This sort of programming has not yet made it into the curriculum of the responding Master’s degree programs. In NH, only one doctoral program in Clinical Psychology has recently developed a systematic – albeit optional – IBH-specific training sequence for their students.

## Most training programs are eager to partner, learn more about IBH workforce needs

Comparison of the “Current Average” and “Future Average” columns of the chart below shows that training program respondents are both fairly enthusiastic about and intending to expand their IBH training (0=pre-contemplation, 1=contemplation, 2=ready to act). Responding social work programs were notably less ambitious in their future plans to prepare students for IBH, despite the strong current and future demand



for BHCs (and specifically, MSWs) reflected in our needs assessment data. Programs that prepare future Care Enhancers were less uniformly ready to enhance IBH training in the future, because behavioral health was less likely to be perceived as a core element of their training missions. The lack of

discipline-specificity of CE roles complicates this picture: roles such as navigator, health coach, community health worker and patient advocate are not reliably linked to a particular training background, despite the presence of some targeted programs in the private sector (health coach) and public sector (community health worker). The programs that are poised and open to learning more about and offering more IBH training in the future, tended to already offer a behavioral health component to their training, albeit one that was not yet specifically tied to primary care or IBH.

## Interpretation and Discussion

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### Characterizing the NH IBH workforce field: Nascent enthusiasm

Our respondents were enthusiastic about the future of IBH in primary care. The safety net providers perceive themselves as providing a high level of IBH, and seemingly view IBH – and the workforce associated with it – as increasingly central to their mission. Almost all of the training programs we talked to expressed interest in being part of a NH-based IBH workforce initiative.

Safety net providers had a more sophisticated view of IBH than did the training programs, although they probably overestimate their current level of integration and underestimate the training and preparation necessary for staff to become an effective part of a well-functioning IBH team. Training institutions are later adopters of IBH than the safety net providers, and many have not decided whether offering any training in behavioral health work in primary care is part of their mission. Relatively few of them recognize or prepare their students for this emerging job market. Some training programs were unaware of the demand for their graduates as part of IBH teams in primary care. Others seemed vaguely aware of the IBH-related job opportunities, but not well positioned to help graduates take advantage of them.

### Conceptualizing and developing the workforce for the four core roles of IBH

These results, and the IBH workforce needs of New Hampshire, can be best understood and addressed by focusing not on the myriad specific degrees, roles, and labels currently in use in primary care settings, but on four basic role categories that together make up the IBH team in primary care: behavioral health clinicians (BHCs), primary care clinicians (PCCs), consulting psychiatric clinicians (CPCs), and Care Enhancers (CEs).

### Train more behavioral health clinicians (BHCs) for a generalist IBH role in primary care

BHCs are licensed mental health or substance abuse therapists. They have Master's or Doctoral degrees. In some sites around the nation, nurses with additional behavioral health training also fill this role. In the clinics we surveyed, the BHC role is filled by Master's level social workers, marriage and family therapists, clinical mental health counselors, and Doctoral level psychologists.

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BHCs in well-integrated primary care settings function quite differently from their colleagues in “specialty” mental health/substance settings or even “co-located” primary care. In fully integrated settings, BHCs are generalists. They provide mental health, substance abuse, and health behavior change services, plus behavioral health and behavior change consultation to other team members (primary care clinicians, CPCs, and CEs). These services are delivered as part of the routine care provided by the primary care healthcare team, rather than offered as a specialty service via referral. BHCs in well-integrated settings offer briefer, more goal-oriented, and more incremental interventions than their counterparts in co-located or specialty settings. BHCs in well-integrated primary care settings serve the entire primary care panel or designated populations of patients rather than a specific behavioral health caseload. BHCs in these settings do not open or close cases; rather, they add behavioral health expertise and sometimes direct service to the overall care of all patients.

In contrast with the perceptions of our NH safety net clinic responders, BHCs require special training to be successful in well-integrated primary care settings. Clinicians trained only in specialty mental health often fail in IBH settings. Hall, Cohen, Davis and their colleagues (2015) reported a study of 19 sites around the country, many of which were selected as exemplars of integrated care. The study found that “Practices [that] were newer to integration underestimated the time and resources needed to train and organizationally socialize (onboard) new clinicians. This underestimating of the necessity of targeted training for integrated practice for behavioral health clinicians was the source of several failures of early program iterations” (p.S41).

Only one doctoral program is explicitly and systematically preparing graduates for the BHC role in primary care. The other relevant programs were generally not aware of whether their graduates worked in primary care. Yet, all of these programs were interested in learning more about how to expand the IBH workforce statewide. Our safety net clinics expressed a great desire for clinicians to fill the role of “substance abuse counselor.” This seems to be a direct and logical response to the opioid crisis. The default to a specialist provider, however, is generally inconsistent with the core tenets of IBH specifically and primary care generally, and may reflect limited exposure to the roles that more generalist-trained BHCs take in opioid and other substance misuse treatment programs in primary care nationally.

Separating the role of substance abuse counselor from BHC creates several problems. The strength of primary care is to engage patients in a generalist approach to care. Adding multiple specialized BH clinicians to a primary care practice would replicate inside the primary care setting the problems endemic in the currently bifurcated mental health/substance abuse treatment systems. Mental disorders, substance misuse, and chronic illness are highly comorbid. To engage patients in care for all their issues requires a service that can offer care for whichever problem the patient is willing to address first and clinicians who can leverage a longitudinal relationship to start where the patient is willing to start when they are ready.

A more immediate argument for BHC generalists has to do with the strictures of the 42CFR regulations on sharing information about substance abuse diagnoses and treatments. The regulations permit sharing of information about substance abuse problems under the following conditions: the setting holds itself out as a general medical service, the substance use and treatment information was not generated by a sub-unit identified with substance abuse diagnosis and treatment, and substance abuse diagnosis and treatment is not the primary function of the provider. In other words, having a specialty Substance Abuse Counselor in a primary care practice would disallow sharing of information without an additional patient release, which would undercut the premise and practice of a team approach.

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IBH works best with a generalist BHC, who is equipped to address mental health, substance abuse, and health behavior issues together or separately, as they arise. In the long run, training BHCs to adequately address the whole array of concerns common to primary care – and to make enhanced referrals to specialty care when warranted – is crucial. Doing so would not prevent primary care practices from dealing with the substance misuse problem head on. It could well be that the first population addressed by the BHC in a primary care practice would be patients with substance use disorders. We need to train generalist BHCs to competence in addressing opioid use, problem drinking, and other common substance misuse conditions in the state. To do this will require educating Masters and Doctoral degree programs about necessary training and documentation of experience needed so that graduates can meet qualifications for the NH MLADC certification. This will prevent a needless internal struggle about whether generalist BHCs are able to deliver the care the state is currently committed to enhancing.

New Hampshire is well supplied with programs that could produce excellent BHCs. Currently, none of the relevant Master's level clinical training programs offer a course that is equivalent to the training programs available in the private sector to prepare mental health clinicians to succeed in primary care. The practices that are in need of BHCs currently prefer MSWs for this role, but other Master's degree or Doctoral programs (Doctor of Psychology, Licensed Mental Health Counselor and Marriage and Family Therapist) could be equally good sources of BHCs.

Rather than expect each individual Master's program to create and insert a new course focused on IBH into their already overcrowded curricula, it may make more sense to develop or contract for a course or certificate program that is equivalent to those offered in the private sector. This course or sequence could be accepted for credit by individual Master's programs, or it could be taken post-degree by students in programs without the latitude to accept it for academic credit.

Experiential training opportunities must go hand in hand with coursework to adequately prepare the BHCs of the future to contribute clinically and programmatically upon graduation. Primary care sites, especially safety net settings, will need adequate support and resources to provide experiential training grounds for BHCs. A doctoral program in Clinical Psychology recently received a grant from the Agency for Healthcare Resources and Services to expand the experiential component of their IBH-specific training program. The best source of sustainable support for experiential training would be to allow sites hosting qualified trainees to bill under Medicaid for their services, as is done in many states. Students in training can also provide a significant service resource if support for supervisory time can be made available.

The quality of the future BHC workforce would be improved if behavioral health profession trainees (psychologists, social workers, counselors) were socialized to primary care through a “ground floor” experience as a Care Enhancer, as part of the experiential component of training. Devoting part of their placement time to Care Enhancer-related work, provides important resources to the primary care practice, trains the student in foundational skills and functions such as patient engagement, and gives them the experience of working within an IBH team.

## Expand the reach of the existing consulting psychiatric clinician (CPCs) workforce

The majority of our clinics are using psychiatrically trained nurse practitioners and advanced practice nurses (53%) rather than psychiatrists (27%) to fill the role of CPC. Practices seem to be using psychiatrists and psychiatric advanced practice nurses largely in a consulting role, supporting the prescribing and care of the PCCs. Access to psychiatric expertise is critical not only to patient care, but also to the care and support of PCCs in IBH settings. Primary care clinicians are comfortable prescribing the medication therapies for a broader array of patients if they have readily accessible consultation with BHCs or CPCs about diagnosis, and with CPCs about prescribing regimens.

New Hampshire has one psychiatry training program, operated by Dartmouth-Hitchcock in Lebanon. The program trains seven general adult residents per year, three child fellows in each of the two years of training, and two sleep medicine fellows, two addiction psychiatry fellows, and one geriatric psychiatry fellow per year. Dartmouth-Hitchcock has a collaborative care program in their primary care clinics in Lebanon (adult and child) and these are active training sites for medical students, adult psychiatry residents, and child fellows. Medical students and psychiatry trainees at Dartmouth are very interested in collaborative care. Residents are exposed to this kind of care in their outpatient training and many focus on it during their elective time in their fourth year of training. Child fellows also are exposed in their outpatient work and there is significant interest in opportunities for this kind of work. Dartmouth-Hitchcock is actively honing the Dartmouth model of collaborative care to address and support anxiety, depression, and substance use disorder care in primary care and anticipates growing training opportunities as this work progresses. Generally speaking, adult and child psychiatrists express considerable interest in providing collaborative care in primary care and would welcome job opportunities in this kind of practice. Many trainees seek to remain in New Hampshire once they complete their training.

We were unable to assess how much of the cause of psychiatrists being in the minority in the CPC workforce is related to the differential cost of a psychiatrist versus an advanced practice nurse, rather than a scarcity of interested psychiatrists. The interest expressed in IBH by members of the Dartmouth psychiatry residency would seem to argue that economics is a factor. Recent proposed changes by Medicare in payment for psychiatric consultation in primary care should be kept in sight as a possible support for engaging psychiatrists more fully in IBH in NH.

Because small, rural practices will probably never be able to employ their own CPCs, and NH-based programs do not have the capacity to solve the national shortage of psychiatric providers, re-education and redeployment of the existing psychiatric resource, in addition to enhanced recruitment of new psychiatrists to the State, may be the best bet to address this part of the workforce challenge. A NH-based statewide psychiatric consultation service modeled after the Massachusetts Child Psychiatry Access Project could provide an important solution. This service averted a psychiatric access crisis in pediatric primary care in Massachusetts, without adding significantly to the overall workforce.

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Retraining psychiatrists currently in practice may offer a short-term approach to improving the workforce of CPCs. The American Psychiatric Association makes available a full day of training in consulting as a psychiatrist in primary care at each of its annual meetings. The curriculum from this course is in the public domain and could be taught through an online or in person format by current experts in primary care psychiatry in the State.

## Help primary care clinicians (PCCs) adapt to IBH

We did not assess the number or role of primary care clinicians (PCCs) (family medicine, internal medicine and pediatric physicians, nurse practitioners and physician assistants) in our survey, because PCC workforce issues have been addressed by other investigators and tracked nationally. We did, however, investigate the role of PCCs in the delivery of IBH and the training of a competent workforce.

Hall, Cohen, Davis, et al, (2015) found that IBH requires primary care clinicians to adapt their practice in several ways. They need to accept and utilize new expertise on the team, review screenings and identify patients needing BHC services, communicate with patients about their behavioral health needs and how the BHC can help, and discuss patient behavioral health needs with the BHC so they (PCC) can guide development of an overall plan of care. This is in addition to their current work diagnosing and prescribing medications for common mental health conditions, such as depression, anxiety, alcohol and opioid use, and ADHD.

While the integration of BHCs and CPCs into primary care is designed to take some of these responsibilities off the shoulders of PCCs, in addition to improving the care they deliver, the process of integration is not without stress. Many will experience the transformation to integrated primary care and concomitant modifications in their role as challenging, even as they often report enjoying their work more. Learning when and how to introduce BHCs into the flow of care, into workflows that the PCCs have developed over many patient care episodes, is often disconcerting. While some experience immediate relief with the additional support, for others it takes many iterations of sharing care of patients with BHCs for PCCs to develop enough trust in their colleagues' skills to become comfortable with this aspect of team care.

PCCs are accustomed to getting on-the-job training through the Continuing Medical Education process. For the last six years, the Department of Psychiatry at Dartmouth has offered a continuing medical education course on mental health and substance use care in primary care for non-psychiatric physicians and nurses, training hundreds of clinicians. This is an important part of preparing PCCs for a transition to integration. We know of no organized programs available at present that train PCCs in the specific dispositions, skills, and techniques that will help them transition effectively and comfortably to the team aspects of IBH practice. Such programs are in development in New England, and at least one will be available by early 2017. Here again, the State might choose to replicate or contract for such a program to make it available as part of the transformation to IBH.

## A modular, functional, and practical approach to expanding Care Enhancers (CEs)

We have chosen to include many roles and labels under the banner of Care Enhancer (navigators, community health workers, care managers, care coordinators, health coaches, patient educators, patient advocates, and there are probably others we couldn't identify). Our survey and discussions find that little standardization in function or title exists for the myriad labels given to the various types of Care Enhancers; a "patient advocate" might do in one practice what a "care coordinator" does in another, and so forth. While the labels vary, the commonalities in the functions they serve within the primary care team are striking. In general, Care Enhancers do one or more of the following:

- 1) create and maintain patient engagement in care within and across health settings,
- 2) address issues of health literacy, adherence and healthy living,
- 3) address social and economic barriers patients face in caring for their health ("social determinants of health")
- 4) keep information flowing between the patient and the rest of the healthcare team.

NH practices expect Care Enhancers to be Bachelor's or Master's prepared, with a preference for some medical and behavioral health training. In other states, practices have tended to default to nurses for many of these roles, only to broaden the acceptable training background as the crucial behavioral elements of the work became apparent. We included medical assistants and registered nurses/bachelor of science nurses in this category because they can also be trained to play a care enhancement role, such as managing depression registries or serving as care managers, as they have in other successful IBH settings nationally, e.g. in Minnesota. Indeed, staff with a wide variety of academic backgrounds and degrees can be successfully trained to handle one or more care enhancer functions.

Care Enhancers are critical to successfully enacting the behavioral and medical aspects of the care of high need populations. Currently, some CEs are trained in the private sector (health coaches), others in the public sector (community health workers), and others through augmentation of more traditional disciplinary training (nurse navigators). Moving forward, we should think of Care Enhancers in terms of the four functions, rather than the dizzying array of academic backgrounds, credentials, and labels applied to the staff that can fill those roles. Thinking in terms of care enhancer functions will provide coherence and conceptual clarity about the nature of the role, as well as more flexibility in how to staff it, while avoiding interdisciplinary conflicts over resources between advocates of one disciplinary background or another.

In "reverse integration" settings, where primary care is brought into specialty behavioral health centers, the CE role of medical care manager has been added resulting in significant effects in improving the delivery of preventive and chronic illness care (Druss, et al, 2010). Training case managers who have worked in behavioral

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health settings in chronic illness care and wellness coaching is similar to training nurse care managers who have been working in medical settings in depression monitoring and patient activation techniques – each needs targeted training to be able to do the whole CE job in IBH.

Because the background of staff filling CE roles is so varied, their training should be modular rather than discipline-specific. Such training should be focused on training Care Enhancers, regardless of background, to competence in the four core functions, allowing for customization that fits with the particular programming of a particular population/primary care practice.

Based on our survey results, the supply of medical assistants in NH may well exceed the demand in the coming years. Medical assistant training could be considered a gateway to the CE role, thus filling a critical IBH workforce need. Medical assistants typically receive two years of post high school training orienting them to the medical setting, the basics of healthcare, and to professionalism as a key part of practice. Medical assistant training could be augmented by modular, post-degree competency-based education in one or many of the CE functions. This strategy could, quite quickly produce a high quality, flexible, and more socioeconomically and racially/ethnically diverse Care Enhancer workforce. Indeed, in some settings, medical assistants have been successfully trained to serve as depression care managers, to assist physicians and BHCs in opioid treatment programs (Mullin, 2016), and to regularly help patients identify and reach their individual health goals as part of a regular primary care visit (Mauksch and Blount, 2014). While the current training structures for health coaches, community health workers, care coordinators, and navigators are likely to continue to develop organically, we believe that retraining existing medical assistants for additional CE responsibilities in any of these roles should also be explored as an additional means for enhancing the IBH workforce.

## **Set the stage for an IBH-specific practice facilitator workforce**

Another workforce role that may become important as the IBH expands, is the role of the IBH-specific practice facilitator. Practice facilitation is an approach to helping primary care practices innovate and improve. The practice facilitation approach has been widely – and effectively – used within the Patient Centered Medical Home movement (Baskerville, Liddy, Hogg, 2012; Nagykaldi, Mold and Aspy, 2005).

Statewide programs aimed at fostering the development of IBH often take a “learning community” approach, with webinars from experts and information exchanged between practices. An excellent example of this sort of programming has been offered by the New Hampshire Citizens Health Initiative over the past year. Perhaps the most sophisticated new resource in this space at the present time is the “Playbook” and “Integration Community” offered by the Integration Academy of the Agency for Healthcare Research and Quality. But the consensus of experts currently leans away from using learning communities as the only resource for helping practices make these changes. Additional time and energy, tailored to specific primary care practices, by practice facilitators is thought to be a necessary part of the resources required to help many practices make the substantial change in mind set as well as clinical routines required to offer successful IBH (Dickinson, 2015).

Practice facilitation has not yet been widely implemented or studied in the transformation of practices to IBH (Dickinson, 2015). Yet the experience of one author (AB) indicates that Patient Centered Medical

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Home (PCMH) practice facilitators – who can be quite successful in helping practices adopt PCMH as a new model – tend to be less successful in facilitating the change to IBH. This could be because the medical expertise, so critical to facilitating the change to PCMH, already exists in abundance in the typical primary care setting, and thus, does not need to be added by the practice facilitator. The expertise critical to the transformation to IBH, however, tends to be thinly supplied in most primary care settings, such that the practice facilitator needs to bring both practice change and behavioral health integration expertise to the table. Planning for the development of an IBH practice facilitation workforce in the state should be part of long range planning. This model has been successful in Maine, and the Center for Behavioral Health Innovation at Antioch also has experience providing technical assistance to IBH practice transformation.

## **Leverage and infuse the highest levels of IBH expertise, across the workforce**

Maximizing the supply of well trained BHCs and CPCs is a good and necessary step in New Hampshire. It is unlikely, however, to completely meet the IBH workforce needs of the future. As more practices venture more substantially into IBH, behavioral health will become a part of more of the array of primary care services (Cohen, Davis, Hall, et al, 2015). This increased need can be partially addressed by increasing the behavioral health expertise of other team members. Some “expertise transfer” is a natural byproduct when IBH team members work together with the same patient (Blount, 1998) and can be amplified when behavioral health experts offer targeted training and regular consultation on cases. Just as psychiatrists have leveraged their expertise in diagnosis and prescribing across a larger front line workforce of PCCs, well-trained BHCs such as psychologists and experienced social workers can leverage their expertise through regular consultation with CEs and PCCs. This allows CEs to be more broadly engaged in BHI when they have easy access to BHCs for difficult patient situations and treatment plans that are not progressing.

## **Toward a “doorways and pathways” model to enlarge, diversify the IBH workforce**

Two approaches to developing a skilled professional workforce in healthcare have emerged: 1) traditional academic training supplemented by (unpaid or low paid) experiential training in practice settings; and 2) training on the job while collecting a salary, sometimes with the help of an academic setting. For the behavioral health workforce in primary care, the former typically precedes the latter. People train as social workers, psychologists, psychiatrists or other counselors, and then receive additional post degree training specific to primary care. This system privileges students with greater access to funds for tuition, who can endure longer periods without an income, and who can take on greater amounts of debt. Despite the best efforts of academic settings to attract and retain diverse student bodies, the resulting workforce tends to reflect the current ethnic and racial distribution of students with greater economic resources in the culture at large.

Academic programs that train behavioral health clinicians do not generally consider themselves a front door to work in primary care. Instead, they generally view and market themselves as the front door to the many possible roles or practice settings afforded by their discipline. Thus, the gulf between traditional disciplinary training and the specific needs for IBH practice in primary care is wide enough that specific post degree training has been necessary in many cases.

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In primary care, new niche roles and the augmentation of old medical roles to include behavioral health components have undercut the traditional hegemony of academic disciplines. Social workers are being transformed into successful care managers, a role that was once the sole province of nurses. Associate's and Bachelor's level staff are succeeding in behavioral health roles that once required a graduate degree, such as functioning as depression clinical specialist or providing behavioral activation for patients with depression. In some places, even peers, fellow patients providing natural support, support are being enlisted and trained to effectively provide psychosocial interventions (Patel, Chowdhary, Rahman, & Verdeli, 2011).

On the job training to increase skill and add credentials could be a more robust pathway than traditional academic training alone toward a larger and more diverse workforce that is specifically trained in and socialized to primary care. Workers become competent in various aspects of functioning in primary care and then get the academic training and credentials to be able to do more complex and more professional roles. This “doorways and pathways” model would offer targeted training, in both academic and post-degree settings, that leverages the existing skills, credentials, and experience of the current healthcare workforce, into ever increasing levels of competence, credentials, and salaries, to satisfy the IBH workforce needs.

Nursing has had success with something approximating this approach. Pathways from licensed practical nurse to registered nurse to bachelor of science nurse to nurse practitioner and to doctor of nursing practice are reasonably well articulated. These pathways are often structured to allow students to continue working as they move up the ladder, interspersed at times with brief periods of full time engagement in an academic program. Theoretically, one could begin as a licensed practical nurse and, while maintaining an income for most of the journey, achieve the status of doctor of nursing practice and primary care provider.

The same sort of ladder could be articulated, probably without great change in existing academic programming, for the behavioral health workforce. Someone could begin as a community health worker and add training as a health coach or experience as a patient advocate, on the way to a degree as a clinical social worker, marriage and family therapist, or certified mental health counselor. Probably because, unlike nursing, each of these roles is viewed as a distinct discipline, the motivation and vision necessary for articulating such a ladder has been lacking. No effort has gone into orienting academic training programs to their possible roles in such a ladder. And most importantly, there has been no effort to recruit students to the doorway positions and articulate the net of pathways that could lead to a career of advancement within primary care or other medical settings. These tasks, articulating the vision of primary care as the central setting for generating its own behavioral health workforce, recruiting willing academic institutions as partners in building a network of ways for workers to improve skills and increase credentialing, and recruiting students to a clear structure of positions and opportunities for advancement, would form an agenda for the building of a long term self-renewing primary care behavioral health workforce.

Articulating the current network of possibilities, along with the employment opportunities and salary levels that are available to be achieved, is the job of an entity with statewide reach, committed to the building of the whole primary care behavioral health workforce, not to one program or discipline. The more clearly this network is articulated, and the more work in primary care is marketed, the more the market will put pressure on training programs to cooperate and support the endeavor. The program that is best at providing training that allows students who are already working at one role to keep working and move to a more complex higher paid role will hold a competitive advantage in the primary care workforce marketplace.

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A robust plan will also consider the role of interpreter as one doorway into the workforce system we are envisioning. The role of professional interpreter in healthcare brings in a wide array of bright bi-lingual and bi-cultural workers who become oriented – through their work – to every aspect of practice in the settings in which they serve. Their skills with language and culture make them uniquely attractive candidates for roles such as navigator or health coach, which can then make some of them good candidates for training to fulfill more complex and professional roles, down the line. This would infuse the IBH workforce with staff who are competent in the languages and cultures the healthcare system now serves poorly, and hungry to refine their skills and credentials to take on increasingly sophisticated clinical duties and improved salaries, while remaining connected to – and hopefully loyal to – the primary care patients they serve.

## **Remove regulatory and payment barriers to the IBH workforce of tomorrow**

Barriers currently impede the use of Master’s level BHCs – other than social workers – in a fee for service environment. Since other Master’s level behavioral health clinicians (e.g., clinical mental health counselors, marriage and family therapists) start at about the same place as clinical social workers in relation to primary care practice (needing a rigorous orientation to primary care and retraining for primary care behavioral health practice), payment barriers that effectively exclude them from the BHC role only serve to limit the potential IBH workforce.

Payment reform offers an opportunity for taking positive steps to expand the workforce in thoughtful ways. It is crucial that regulators and policy formulators be aware of training and workforce issues and that they allow and support the full array of behavioral health clinicians and the full array of trainees for behavioral health clinician to be able to provide services in primary care under payment transformation whether or not they can be recognized under fee for service plans as eligible to bill. In Massachusetts, the explicit inclusion of trainees in approved training programs and any licensed behavioral health clinician as providers of behavioral health services in primary care made integrated care financially viable for many primary care practices serving Medicaid patients in Mass Health’s 2014 Primary Care Payment Reform program.

## **Keep in mind our limited focus and sample, when considering these conclusions**

We have chosen to assess the workforce needed for the level of integration that is recommended by accreditation agencies such as NCQA, and state plans such as the 1115 Medicaid Waiver. We assessed the workforce needs of safety net clinics practicing a fairly rudimentary form of integration, within the current – not future – regulatory and payment environment. As IBH practice in these clinics matures, in concert with a change to bundled payments of some sort, there will be an increasing need for Behavioral Health Clinicians and Care Enhancers in particular. Our recommendations anticipate some of these changes.

Our primary care sample consisted of 71% of the primary care safety net settings in NH. We should not generalize these findings to other providers that serve a substantial portion of the Medicaid-eligible patients in the state (e.g., Dartmouth-Hitchcock clinics). Likewise, only 40% of the training programs we contacted completed the interview, so these findings do not represent all relevant NH training programs.

# Recommendations and Next Steps

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## Increase training-practice collaboration and communication

Our data, in combination with the national literature, points to gaps in the present and future IBH workforce. These gaps are perpetuated by the lack of contact between primary care settings and academic training programs. Primary care has not yet invested in developing its own workforce, and academic programs are not yet aware of the IBH workforce needs. To create an environment that can produce the BH workforce of the future, regular contact and communication between primary care, academic programs, and post degree training services is needed. Each has important needs to express and lessons to teach, in generating IBH workforce solutions.

## Launch NH IBH workforce development network through one-day summit

One of the first tasks in building NH's workforce development capacity is to bring together primary care sites, academic programs, and post degree training services, along with health systems, policy leaders, and national experts, in a one-day IBH workforce summit. Other key NH IBH workforce stakeholders should be invited as well. The purpose of the summit would be to:

- 1) Initiate contact and communication among IBH workforce stakeholders
- 2) Develop shared understanding of NH's IBH workforce needs in light of the national literature
- 3) Sketch a shared vision of the NH workforce development network of the future
- 4) Identify representatives and institutions that are willing to invest time and effort to move the IBH vision

## Develop an IBH workforce advisory group (IWAG)

By the end of the summit, a representative mix of primary care, training institution, and other key stakeholders should be identified to serve as potential members of a NH IBH workforce advisory group (IWAG). The IWAG should also be in contact with national experts and out of state IBH training programs, such as the Center for Integrated Primary Care at the University of Massachusetts Medical School. The IWAG would meet monthly, by conference call or in person, to 1) foster the ongoing education and communication between key IBH workforce stakeholders; and 2) develop a NH IBH workforce development strategic plan.

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## Create an IBH workforce development strategic plan

The NH IBH workforce development strategic plan should address a minimum of four priority areas.

- Marketing and recruitment of current and future students into IBH careers, particularly through the participating academic and training programs.
- Strengthening NH's IBH leadership, infrastructure, regulatory, and policy environment. For instance, the plan might call for advocacy for primary care settings to receive reimbursement for the services provided by supervised BHC trainees.
- Bulding out the “doorways and pathways” model discussed earlier in this report
- Designing and identifying an IBH workforce backbone structure/entity

## Backbone entity implements plan, supports ongoing improvement of IBH in NH

The process of developing and implementing a long-term primary care behavioral health workforce plan for New Hampshire will be accomplished with the cooperation of many stakeholders. Those stakeholders will need an organization that convenes, facilitates, guides and expedites all along the way. This backbone entity would be charged with educating, marketing, and advocating for IBH among key constituencies; convening and coordinating key players; implementing, evaluating, and modifying the strategic plan over time; and providing access to IBH-related training, technical assistance, and practice facilitation resources to training institutions, primary care practices, and other key IBH stakeholders throughout the state (e.g., Integrated Delivery Networks, under NH's 1115 Medicaid waiver). It should have access to broad and deep knowledge about the natural history of IBH and the intricacies of the clinical routines and staff roles through which it is carried out. Whether in the information clearinghouse, technical assistance, or training and consulting role, the skills and knowledge of the backbone entity will be crucial to the development of IBH in New Hampshire.

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# Appendix A. Primary Care Needs Assessment Survey

## FQHC and RHC Clinic Survey

### Integrated Behavioral Health Workforce Survey

1. Please tell us about the academic background of staff who contribute to Behavioral Health care in your practice. Please indicate all backgrounds if multiple staff members fill the same role.

Please choose from this list:

Behavioral Health role	How many staff now in this role?	MD/DO Psychiatrist MD/DO NP/APN PA (Physician Asst.) RN/BSN LPN MA (Medical Asst.)	Psychologist MSW MFT LMHC BSW Other Bachelor's Associate's Degree Other Degree (list)
Prescriber of Psychotropic Meds <i>(e.g. PCP, Psych MD, Psych APN)</i>			
Behavioral Health Clinician <i>(e.g. Psychologist, Social Worker, Counselor)</i>			
Care Manager			
Health Coach			
Substance Abuse Counselor			
Nurse			
Medical Assistant			
Community Health Worker			
Patient Advocate			
Care Coordinator			
Patient Educator			
Navigator			
Other (Please list)			

2. This is a 2-part question: To what extent do people hired for this role enter the job with the competencies necessary to perform the behavioral health aspects of it well? How much specific training is required to fill the Behavioral Health portion of each role?

**RTG** = Ready to go (usually) in the role when they completed training for the discipline

**OJT** = On the job training needed for the behavioral health part of their role (done at your practice)

**STN** = Substantive additional training from external sources needed for the behavioral health part of their role

<b>Behavioral Health role</b>	<b>Ready to Go</b>	<b>On the Job Training Needed</b>	<b>Substantive Additional Training Needed</b>	<b>Amount of Specific Training Needed to Fill Behavioral Health portion of the role</b> <b>0 = None</b> <b>1 = A Little</b> <b>2 = Some</b> <b>3 = Moderate Amount</b> <b>4 = Great Amount</b>
Prescriber of Psychotropic Meds <i>(e.g. PCP, Psych MD, Psych APN)</i>				
Behavioral Health Clinician <i>(e.g. Psychologist, Social Worker, Counselor)</i>				
Care Manager				
Health Coach				
Substance Abuse Counselor				
Nurse				
Medical Assistant				
Community Health Worker				
Patient Advocate				
Care Coordinator				
Patient Educator				
Navigator				
Other (Please list)				

3. Please tell us how many workers who contribute to Behavioral Health care in the practice you WISH you had now and how many you want FIVE years from now. Tell us also which discipline you would hire to fill this role.

Ideal Academic Discipline to fill the role

Behavioral Health role	# you wish for NOW	# you want in 5 years	MD/DO Psychiatrist MD/DO NP/APN PA (Physician Asst.) RN/BSN LPN MA (Medical Asst.)	Psychologist MSW MFT LMHC BSW Other Bachelor's Associate's Degree Other Degree (list)
Prescriber of Psychotropic Meds <i>(e.g. PCP, Psych MD, Psych APN)</i>				
Behavioral Health Clinician <i>(e.g. Psychologist, Social Worker, Counselor)</i>				
Care Manager				
Health Coach				
Substance Abuse Counselor				
Nurse				
Medical Assistant				
Community Health Worker				
Patient Advocate				
Care Coordinator				
Patient Educator				
Navigator				
Other (Please list)				

4. Please tell us how difficult it is to fill the Behavioral Health portion of each role, by checking the best box.

Level of Difficulty in finding adequately prepared staff for the BH part of the role

Behavioral Health role	Very Easy	Fairly Easy	Same as Non-BH roles	Fairly Difficult	Very Difficult
Prescriber of Psychotropic Meds <i>(e.g. PCP, Psych MD, Psych APN)</i>					
Behavioral Health Clinician <i>(e.g. Psychologist, Social Worker, Counselor)</i>					
Care Manager					
Health Coach					
Substance Abuse Counselor					
Nurse					
Medical Assistant					
Community Health Worker					
Patient Advocate					
Care Coordinator					
Patient Educator					
Navigator					
Other (Please list)					

5. At what level of behavioral health integration is your practice right now? (Check the one closest to your level) Please see [www.integration.samhsa.gov](http://www.integration.samhsa.gov) if you would like more description about these models.

Coordinated, Level 1: Minimal Collaboration	
Coordinated, Level 2: Basic Collaboration at a Distance	
Co-Located, Level 3: Basic Collaboration Onsite between medical and BH services	
Co-Located, Level 4: Close Collaboration Onsite with some System Integration	
Integrated, Level 5: Close Collaboration Approaching an Integrated Practice	
Integrated, Level 6: Full Collaboration in a Transformed/Merged Integrated Practice	
Don't Know	

**THANKS FOR YOUR PARTICIPATION!!**

## Appendix B. List of Clinics

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### Organization

### Site type

Ammonoosuc Community Health Services, Inc.	Federally Qualified Health Center
Antrim Medical Group	Rural Health Clinic
Coos County Family Health Services, Inc.	Federally Qualified Health Center
Rowe Health Center (Cottage Hospital)	Rural Health Clinic
Families First Health and Support Center	Federally Qualified Health Center
Goodwin Community Health	Federally Qualified Health Center
Harbor Care Health and Wellness Center (Harbor Homes)	Federally Qualified Health Center
Health Care for the Homeless Program	Federally Qualified Health Center
HealthFirst Family Care Center	Federally Qualified Health Center
Indian Stream Health Center	Federally Qualified Health Center
Lamprey Health Care	Federally Qualified Health Center
Manchester Community Health Center and Child Health Services	Federally Qualified Health Center
Mid-State Health Center	Federally Qualified Health Center
Newfound Family practice	Rural Health Clinic
Newport Health Center	Rural Health Clinic
North Country Primary Care	Rural Health Clinic
Saco River Medical Associates	Rural Health Clinic
Speare Primary Care	Rural Health Clinic
Weeks Medical Center	Rural Health Clinic
White Mountain Community Health Center	Community Health Center
Concord Family Health Center	Community Health Center

## Appendix C. List of Training Programs

Degree	Program	Institution
<b>Consulting Psychiatric Clinicians</b>		
M.D.	Family Medicine Residency	Dartmouth College
M.D.	Psychiatry Residency	
MS Family Nurse Practitioner	Nursing	Massachusetts College of Pharmacy and Health Sciences (MCPHS) - Manchester
		University of NH
		Rivier University
MS Psychiatric/Mental Health Nurse Practitioner	Nursing	Rivier University
MA	Physician Assistant	Massachusetts College of Pharmacy and Health Sciences (MCPHS) - Manchester
<b>Behavioral Health Clinicians</b>		
PsyD	Clinical Psychology	Antioch University New England
PsyD	Counseling & School Psychology	Rivier University
MA	Clinical Mental Health Counseling	Antioch University New England
MS	Clinical Mental Health Counseling	Rivier University
MA, PhD	Marriage and Family Therapy	New England College
		Plymouth State University
		Southern NH University
MS	Couples and Family Therapy	Plymouth State University
MS	Psychology/Clinical Psychology	Hellenic American University
		Rivier University
MSW	Social Work	University of NH
N/A	Predoctoral Psychology Internship	Dartmouth College
N/A	Concord Hospital Internship Program	Concord Hospital
<b>Care Enhancers</b>		
BS	Health Science	New England College
		Keene State College
AS	Health Science	Manchester Community College
		Concord Community College
		White Mountains Community College
BS or Undergraduate Major	Health Education and Promotion/Health and Wellness	Plymouth State University
		Southern NH University
		Granite State College
		Colby-Sawyer College
AS	Health Education and Promotion/Health and Wellness	White Mountains Community College

<b>Degree</b>	<b>Program</b>	<b>Institution</b>
BS or Undergraduate Major	Public Health	Rivier University
		Franklin Pierce University
		Colby-Sawyer College
LPN to RN	Nursing	Concord Community College
Licensed Nursing Assistant	Nursing	Salter School of Nursing
Patient Care Technician	Nursing	Salter School of Nursing
MS	Nursing	Franklin Pierce University
		Southern NH University
MS Clinical Nurse Leader	Nursing	Southern NH University
MS Nursing Patient Safety and Quality	Nursing	Southern NH University
AS	Medical Assistant	Manchester Community College
		White Mountains Community College
Certificate	Medical Assistant	Rivier Valley Community College
N/A	Eating Disorders Institute	Plymouth State University
Community Health Worker Training/Other Trainings	Southern Area Health Education Center	
Various Trainings	Northern Area Health Education Center	
N/A	NH Children's Behavioral Health Network	
N/A	NH Training Institute on Addictive Disorders	
Degree Key: Degree Key: BA=bachelor of arts; BS=bachelor of science; AS=associate of science; MA=master of arts; MS=master of science; BSW=bachelor of social work; MSW=master of social work; LPN=licensed practical nurse; RN=registered nurse; MD=medical doctor; PsyD=doctor of psychology; PhD=doctor of philosophy		

## Appendix D. Training Program Interview Protocol

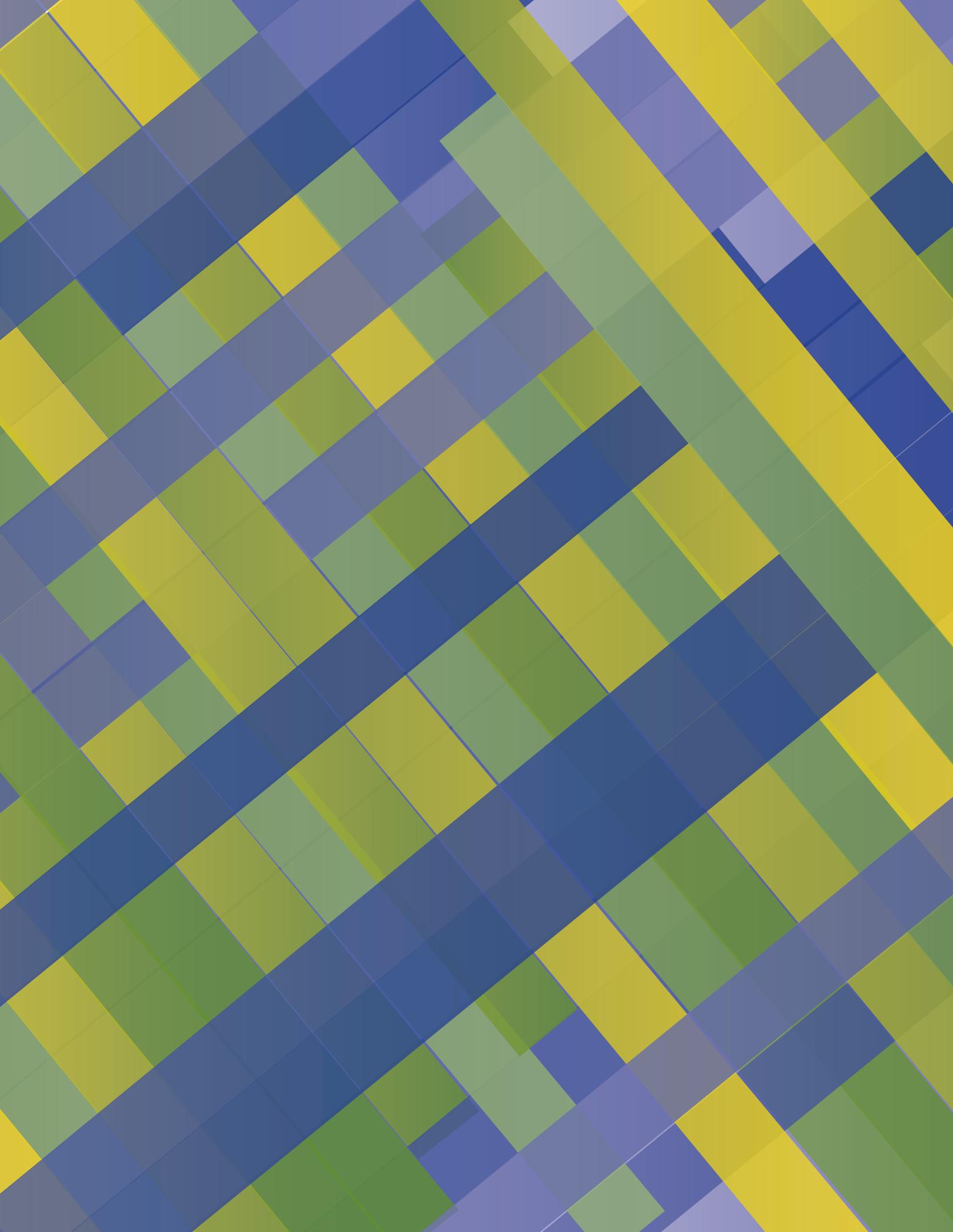
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1. Do you know of graduates doing work in primary care related to behavioral health? By primary care, we mean family medicine, general internal medicine, or general pediatrics.
2. What parts of your program, either academic or experiential, do you see intentionally focused on training in working in primary care and working as part of an interdisciplinary integrated primary care team?
3. Is your program interested in focusing more on this area of training in the future? If so, what do you envision your program doing to make this happen?
4. We're interested in the potential of bringing together multiple training programs to organize and expand the state's ability to produce or develop a behavioral health workforce for primary care. Would you be interested in being part of a larger workforce initiative focused on this type of training expansion, including in inter-institutional, interdisciplinary kind of ways?
5. Who else or what other programs in the state do you know of that are doing similar training?









# New Hampshire Primary Care Behavioral Health Workforce Development Plan

By Alexander Blount

With the guidance and support of: Laura J Bilodeau, Annamarie Cioffari, James Fauth, Nancy Frank, Suzanne Gaetiens-Oleson, Hwasun Garin, Joni Haley, Fred Kelsey, Will Lusenhop, JoAnne Malloy, Patrick Miller, Stephanie Pagliuca



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# Beginning and Purpose

Behavioral health conditions are ubiquitous and debilitating; they exact staggering burdens on individuals, families, and societies alike (Kessler et al., 2005; Kessler et al., 2009). Although effective treatments exist, most people with behavioral health conditions neither seek nor receive adequate treatment (Kessler et al., 2005). Of those that do, most seek help in primary care settings that consistently under-detect and under-treat behavioral health conditions (Coyne, Thompson, Klinkman, & Nease, 2002; Mertens, Lu, Parthasarathy, Moore, & Weisner, 2003; Schulberg, Block, & Madonia, 1996).

Experts have advocated for the integration of behavioral health (IBH) into primary care settings as the most effective way to close the behavioral health treatment gap (World Health Organization, 2008). Numerous randomized clinical trials indicate that IBH can enhance the detection, uptake, effectiveness, and cost effectiveness of behavioral health care in primary care settings (Butler et al., 2008). The low-intensity behavioral health interventions offered in integrated care settings are best suited to mild to moderate levels of emotional distress, whereas more severe and chronic emotional distress responds best to specialty mental health care (Dickinson et al., 2005; Krahn et al., 2006). Nevertheless, widespread, effective, and financially sustainable implementation of IBH has proven elusive in settings of usual primary care (Alexander, Arnkoff, & Glass, 2010; Pincus, 2003).

Among the barriers to successful dissemination and translation of IBH has been a limited and poorly equipped workforce. National estimates indicate that the behavioral health workforce is insufficient to meet the need of patients in our safety net primary care settings (Burke et al., 2013). The problem extends beyond the limited pool of behavioral health providers, to inadequate preparation; the current behavioral health and primary care workforce lacks the training, acculturation, skills, attitudes, and leadership qualities necessary to successfully work as a team to enact IBH (Workforce / SAMHSA-HRSA, n.d.). Limited didactic and experiential training opportunities continue to hamper the dissemination and implementation of IBH (Hall et al., 2015).

New Hampshire is not an exception in this regard. A recent report commissioned by the Endowment for Health and conducted by Cherokee Health Systems highlighted the perception among key stakeholders that NH lacks an adequate IBH workforce (Cherokee Health Systems, 2014). Respondents highlighted a lack of qualified behaviorists, a confusing licensing environment, a shortage of psychiatry, and an overall aging workforce, as major impediments to IBH. Workforce shortages and inadequate preparation extended to the primary care/medical workforce, as well. The aforementioned problems are further compounded by the lack of adequate specialty mental health care and the rural nature of many NH communities; the former places heavier behavioral health burdens on primary care practices, while the latter makes it difficult to recruit, train, and retain qualified professionals.

The Cherokee (2014) report advocated for a multi-pronged workforce development strategy, including but not limited to developing a statewide workforce plan that articulates the number and types of workforce needed, considering ways to expand the workforce pipeline, and advocating for policy changes to support workforce development.

# Beginning and Purpose

## Who will provide Integrated Primary Care?: The New Hampshire Primary Care Workforce Assessment

In the Spring of 2016, the Center for Behavioral Health Innovation of Antioch University New England conducted a survey of the current state workforce in primary care behavioral health as well as the needs for the next 5 years. The survey focused on Federally Qualified Health Centers and Rural Health Centers which were termed “safety net providers,” the sites in the state that serve the majority of the low income population with the highest burden of medical and behavioral challenges. The report was published in October of 2016.

The Workforce Report can be downloaded from the BHI website.  
<https://www.antioch.edu/new-england/resources/centers-institutes/center-behavioral-health-innovation/>

The report found that safety net providers are committed to integrating Behavioral Health into their medical services. They reported that they could use 60% more licensed behavioral health clinicians than they have now and expect to need 97% more in 5 years. The academic programs that are training masters and doctoral clinicians, with the exception of one program, are not orienting or training their students for work in primary care, though all would like to learn more about integration and how their students could contribute. In general, training programs that prepare masters and doctoral level therapists are not aware of the additional training that mental health and substance abuse clinicians need before they can function effectively in the different environment of primary care.

The report also examined ways in which non-clinician staff who are involved in patient services that require behavioral skills can train to become Behavioral Health Clinicians while on the job. These roles, such as health coaches navigators, care managers, care coordinators, medical assistants and community health workers, were collected

under a category called "Care Enhancers" by the report. This would allow primary care to train part of its own future workforce with the support of academic programs that can allow staff to become trained as therapists with masters degrees without having to leave their jobs to do so.

# Creation and Implementation

## NH Primary Care Behavioral Health Workforce Strategic Planning Committee

In October of 2016, a meeting was held to present the results of the Workforce Report. Forty-four (44) people attended the meeting from almost every stakeholder group and almost every area of New Hampshire. At the meeting, the workforce study's findings were presented and an invitation to participate in the creation of a plan to impact the primary care behavioral health workforce was issued. Those present, and later, a few other interested parties who were unable to attend, were offered the opportunity to be on the planning committee that actually shaped the new workforce plan. Attendees were also offered the chance to contribute without going to additional meetings by being part of a larger group, the "Resource Committee," that would be kept aware of the progress of the planning committee and given opportunities to have input as the plan was developed. Monthly meetings of the planning committee were set up and took place December, 2016 – June, 2017. The resulting plan was read and discussed by every member of the committee as it was being developed. Committee members offered substantive changes and additions which were incorporated into the final plan.

The full Resource Committee was shown the plan in developing draft form on two occasions. They either approved of what they saw or they too made suggestions that were incorporated into the final plan.

## Implementation

The implementation of the plan will be staffed by the Center for Behavioral Health Innovation at Antioch University New England. Alexander Blount, EdD, will be the Principal Investigator leading a team of supporting faculty and staff. Potential partners in each activity are listed in the Plan. The implementation of the plan must be perceived as a statewide effort in which many stakeholders participate, just as the creation of the plan has been. The list of partners currently identified to participate is not closed. As new potential partners are identified, they may be added to activities to which they can contribute.

# Highlights of the Plan

The plan is organized sequentially according to activities that will be undertaken. Each activity is offered with the overall goal that it serves and sometimes with larger objectives that serve that goal of which the activity is a part. As part of the activity, a list of deliverables is included and any additional indicators that would show that the activity had been completed successfully is offered.

A Gantt chart is included that group the activities by goal and shows the general time frame projected for each activity.

There are three general goals for the plan: 1. Improve the skills of the current behavioral health workforce in primary care, 2. Develop the future primary care behavioral health workforce, 3. Provide support so that primary care practices can evolve their integrated behavioral health programming to take advantage of the developing workforce.

## 1) The Current Primary Care Behavioral Health (PCBH) Workforce

The Workforce Report and the current literature about PCBH workforce highlight the fact that substantial training is required to prepare a behavioral health clinician trained in providing specialty mental health or substance abuse services to succeed as part of a health team in primary care. To help this training be more broadly available for BH clinicians in New Hampshire, a list of the available post-degree training programs will be assembled. These will be programs that have been evaluated to show they are effective at delivering the necessary competencies to be effective in PCBH. To make these programs more available to current workers, the project will attempt to connect with the workforce efforts of the New Hampshire Integrated Delivery Networks.

## 2) The Future Primary Care Behavioral Health Workforce

In order to grow and improve the future primary care workforce, several activities will be undertaken: a) Efforts will be made to improve

the ability of current graduate programs to orient to and prepare students for PCBH practice. b) A career ladder will be developed to help current staff members on primary care health teams receive training and appropriate credentials so they can provide PCBH services. c) A list of competencies that undergird each step in the career ladder will be defined to help employers and academic programs match their efforts in developing the ladder. d) A web portal will be created that will serve the PCBH workforce needs of the state. The products of the multiple activities in the plan plus other useful resources will reside on this portal.

## 3) Integrated Leadership and Workflows

This will involve helping practices coordinate behavioral health development along with quality improvements they must make for other accreditation such as PCMH, helping in training the current state workforce of practice transformation facilitators, creating tools to help practices become experiential training sites for the next generation of behavioral health clinicians and other workers, attending to the development of materials designed to support integrated behavioral health in pediatric care, and creating orientation materials for primary care administrators in the benefits of PCBH and in training the next generation of workforce

# Plan: Timeline



# Plan: Goals, Objectives, Activities, and Partners

Strategies/Activities to pursue	Goals	Objectives	Start	End	Deliverables	Indicators	Responsible Organization/Other Participants
Generate a list of efforts by the statewide and IDN workforce committees	Improve the ability of practices to create integrated workflows for patient care which become possible as training of PCBH workforce improves	Improve communication between workforce efforts in New Hampshire	9/1/2017	11/30/2017	The list		AUNE BHI/Statewide IDN Workforce Committee
Assemble a list of currently available training that has been evaluated as effective	Increase competence of current PCBH Workforce	Obtain access to quality and affordable post-degree PCBH training and coaching	9/1/2017	11/30/2017	List with descriptions and links	List has been distributed by Citizen's Health Initiative (CHI), Endowment for Health (EFH), and IDN workforce committees	AUNE BHI
Make a list of MH masters programs that can lead to licensure while allowing job retention, including time required, experiential components and	Improve the quality and size of the future PCBH workforce	Create a career ladder for current primary care staff to become PCBH clinicians	9/1/2017	12/31/2017	List of programs in NH or easily available in NH with proven record of successfully preparing students for licensure is complete	List becomes part of career ladder on Portal.	AUNE BHI in conversation with programs and licensing boards
Enlist graduate and undergraduate programs for input their needs for modules describing primary care and PCBH	Improve the quality and size of the future PCBH workforce	Improve ability of current graduate and undergraduate programs to interest students in and orient students to work in primary care.	9/1/2017	2/28/2018	Outline of modules' content supported by majority of programs	Work begins on creating modules at 3 months from launch	AUNE BHI/UNH SW, UNH APRN, SNHU MHC, MCC, AUNE MHC
Develop a PCMH/NCQA "walk across" between latest requirements for certification and evidence based BHI.	Provide practices with access to guidance about the need for integration	Improve the synergy between other requirements of practices (PCMH and others) with the process of behavioral health integration	9/1/2017	2/28/2018	Graph of the NCQA requirements that are part of integrated care.	Graphic is on the portal	AUNE BHI + CHI

Strategies/Activities to pursue	Goals	Objectives	Start	End	Deliverables	Indicators	Responsible Organization/Other Participants
Negotiate a rate for any PCBH clinician in NH from one or more programs and find free quality programs if they exist.	Increase competence of current PCBH workforce	Obtain access to quality and affordable post-degree PCBH training and coaching	12/1/2017	2/28/2018	Enhance the list of descriptions with rates available to NH clinicians	List has rates lower than program websites for at least one and preferably more programs.	AUNE BHI/CHI+ state IDN workforce leadership
Approach workforce committees from of the IDNs for funds for a certain number clinicians per year from their individual	Increase competence of current PCBH workforce	Obtain access to quality and affordable post-degree PCBH training and coaching	12/1/2017	2/28/2018	Proposals presented to all IDNs	Some new funds from other than the primary care practices paying for training in PCBH.	AUNE BHI/CHI +state IDN Workforce leadership
Create a webinar that explains the possible transformations in practice made possible by improved BHC training.	Improve the ability of practices to create integrated workflows for patient care which become possible as training of BHC workforce improves	Improve sophistication of medical and administrative leaders in PC settings about differences in "levels" of integration and the concomitant benefits for patients and	1/1/2018	7/1/2018	Webinar is prepared	Webinar is delivered and archived on the workforce portal.	AUNE BHI/CHI
Make a list of other Care Enhancer roles and the training needed for each role and expected starting salary range.	Improve the quality and size of the future PCBH workforce	Create a career ladder for current primary care staff to become PCBH clinicians	3/1/2018	6/30/2018	List of programs in NH with record of placing graduates in primary care, organized by CE role	List becomes part of career ladder on Portal	AUNE BHI/AHEC in consultation with sites and disciplines (MA, RN, BSW, Health Coach, CHW, Medical Interpreter)
Develop modules that can be taught by any psychiatric APRN program on the role of psychiatric prescribers on the PC health team.	Improve the quality and size of the future PCBH workforce	Improve ability of current graduate programs to interest students in and orient students to work in primary care.	3/1/2018	8/31/2018	2-3 one-hour modules with powerpoints and readings.	Modules posted on the web for universal download.	AUNE BHI/UNH APRN
Develop modules that can be taught by any undergraduate, masters or doctoral program on what primary care and PCBH	Improve the quality and size of the future PCBH workforce	Improve ability of current graduate and undergraduate programs to interest students in and orient students to work in	3/1/2018	8/31/2018	2-3 one-hour modules with powerpoints and readings.	Modules posted on the web for universal download.	AUNE BHI/UNH SW, SNHU MHC, MCC, AUNE MHC

Strategies/Activities to pursue	Goals	Objectives	Start	End	Deliverables	Indicators	Responsible Organization/Other Participants
Attempt to involve representatives of academic programs in cooperating for standardization in supervisory requirements and in creating a manual/toolkit for training sites that is interdisciplinary. Offer live Q&A and coaching available to BH clinicians to enhance training experience and to help with targeted	Improve the quality and size of the future PCBH workforce	Improve experiential training opportunities in primary care for BHCs in graduate training	3/1/2018	8/31/2018	Conduct initial meeting or survey individually to assess who is willing to volunteer to be part of the manual creation process	Put descriptions of process in proposal that is sent.	AUNE BHI/UNH SW, SNHU MHC, MCC, AUNE MHC + AHEC
Create and maintain a web portal for current workforce and students offering an orientation to PCBH work, and links to various training	Increase competence of current PCBH workforce	Obtain access to quality and affordable post-degree PCBH training and coaching	3/1/2018	8/31/2019	Monthly video Q&As with Dr. Blount and other resources begun	Meetings begun with strong evaluations	AUNE BHI
Offer live Q&A and coaching available to BH clinicians to enhance training experience and to help with targeted	Improve the quality and size of the future PCBH workforce	Improve the ability of current workforce and future workforce to be oriented to primary care, PCBH and training options.	3/1/2018	8/31/2019	Place enhanced list of training options and cost, plus asynchronous access to modules on primary care and PCBH on the portal.	Modules, links, and lists posted on portal for universal download.	AUNE BHI AHEC
Create a competency list for care enhancers in BH roles in PC	Improve the quality and size of the future PCBH workforce	Create a career ladder for current primary care staff to become PCBH clinicians	3/1/2018	8/31/2019	Offer an outline of the BH roles that are being filled by non-clinician team members and introduce the concept of "care enhancer". Assemble a multi-disciplinary meeting of PC staff to work on competency list for various	List is developed, disseminated and exists on the portal.	AUNE BHI + Consultant
Create and deliver a training for primary care sites that have BHCs on staff who could supervise to maximize ease and clarify benefits of introducing trainee	Improve the quality and size of the future PCBH workforce	Improve experiential training opportunities in Primary Care for BHCs in graduate training	3/1/2018	8/31/2019	Prepare series of short webinars.	Webinars delivered and recordings reside on the portal.	AUNE BHI/UNH SW, SNHU MHC, MCC, AUNE MHC

Strategies/Activities to pursue	Goals	Objectives	Start	End	Deliverables	Indicators	Responsible Organization/Other Participants
Provide an evidence based outline of programs using CHI that generate revenue or save cost outside of FFS	Provide practices with access to guidance about the need for integration	Improve the synergy between other requirements of practices (PCMH and others) with the process of behavioral health integration	3/1/2018	9/1/2018	Brief highlight of revenue evidence	Highlight is on the portal	AUNE BHI + CHI
Create and deliver training program in behavioral health integration for practice facilitators in CHI's practice transformation	Improve the ability of practices to create integrated workflows for patient care which become possible as training of BHC workforce improves	Offer on site facilitation in developing new workflows taking advantage of trained BHCs	3/1/2018	8/31/2019	Needs assessment with facilitators and survey of practices. Design of program to meet identified competency needs.	Training program is evaluated as increasing competency by facilitators using retrospective pre-test methodology	AUNE BHI + CHI
Create webinars on the behavioral health in pediatric care designed for PCPs and BH clinicians	Improve the ability of practices to create integrated workflows for patient care which become possible as training of BHC workforce improves	Help to improve the rate of BHI in the care of children in NH by focusing some attention to workflows in pediatric settings.	3/1/2018	8/31/2019	2 webinars of the practices particular to pediatric integrated primary care	Programs delivered on line and reside on portal.	AUNE BHI/Child Health services
Assemble career ladder graphically with appropriate links so a person not in primary care can see the steps needed to get to BHC while working in primary care in other roles.	Improve the quality and size of the future PCBH workforce	Create a career ladder for current primary care staff to become PCBH clinicians	6/30/2018	8/31/2019	Career ladder with training requirements, salary levels and links to programs completed	Career ladder up on the Primary Care Job Portal	AUNE BHI/AHEC, statewide IDN workforce committee, graphics consultant

# Strategic Planning Committee Members

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